

# ATLANTIS HEALTH PLAN

## Broker Checklist for Enrolling NY Small Group

1<sup>st</sup> of the month only. The 15<sup>th</sup> of the month is acceptable ONLY if the prior plan terminates on the 14<sup>th</sup>

- Company check Payable to "Atlantis Health Plan"
- Group Agreement Form
- Employee enrollment forms
- Waivers of coverage (if applicable)
- Applicable Tax Documentation (example: NYS-45)
- Late Paperwork Form if submitted later than the 25<sup>th</sup> of the prior month
- Credit/Debit Card Payment Authorization Form (if applicable)
- **Broker to be Paid**

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Please be reminded that for your protection and ours, we cannot alter any paperwork submitted to us, and we cannot submit any paperwork which is missing critical information.

**REMINDER – Please attach a copy of the group's termination letter that you or the client sent to the prior carrier.**

<b>Year 2011 Schedule</b>	
Paperwork is required by Savoy Associates 12 business days prior to the effective date.	
<u>Requested Effective Date</u>	<u>Case Submission Deadline</u>
1/1	12/10
2/1	1/13
3/1	2/10
4/1	3/16
5/1	4/13
6/1	5/13
7/1	6/15
8/1	7/15
9/1	8/16
10/1	9/14
11/1	10/14
12/1	11/10
<b>New Business: 1st Only</b>	

### **INCOMPLETE PAPERWORK CANNOT BE PROCESSED**

GENERAL AGENT:

#### **SAVOY ASSOCIATES**

2 Penn Plaza  
15th Floor, Suite 1500  
New York, New York 10121

**\*if you are working with a NJ sales team, please send this enrollment kit to their office.**

25B Hanover Road, Suite 220  
Florham Park, NJ 07932  
973.377.2220

4 AAA Drive, Suite 205  
Hamilton, NJ 08691  
609.584.8112



## SMALL GROUP/SOLE PROPRIETOR ELIGIBILITY SHEET

1. The group must be actively in business with a street address in one of the five Boroughs: Manhattan, Brooklyn, Queens, Bronx and Staten Island.
2. Full time is defined as actively at work at least 20 hours per week. Groups of one can be submitted only when accompanied by a waiver from the second eligible employee. **Sole Proprietor cases must be submitted with a Schedule C tax form showing a fulltime annual minimum income of \$15,000.**
3. Owners, Partners and officers must meet minimum hourly actively at work requirements.
4. POS participation requirement is 50% participation after spousal waivers. There are no minimum requirements for HMO groups. Employees not electing coverage must submit a waiver form with case submission.
5. Atlantis requires all enrolling subscribers to reside or work in the contracted area: Manhattan, Queens, Brooklyn, Staten Island and Bronx.
6. Medicare recipients are eligible so long as they meet the criteria #2.
7. Eligible dependents are defined as legally married spouse or a legally dependent child up to the age 19. Student rider up to 23 included in community rates if financially dependent and enrolled as a full-time student at an accredited educational institution. Rider to age 25 available.
8. The following are excluded from eligibility and coverage:
  - A. Household help.
  - B. Seasonal Workers & temporary personnel.
  - C. Retirees.
9. Should Atlantis Health Plan determine that group information is materially false, we reserve the right to terminate or deny coverage.



## **ENROLLMENT & WAITING PERIODS**

1. Groups are eligible for coverage on the 1<sup>st</sup> or the 15<sup>th</sup> of the month only. We will accept 15<sup>th</sup> of the month effective dates only when an existing policy (effective 15<sup>th</sup> of the month) is in place or if there was no prior coverage.
2. Open enrollment will be held once a year, 30 days prior to renewal date.
3. PLAN CHANGES. An official at the company should submit plan changes to Atlantis Health Plan no later than one month after initial enrollment. If no changes are made, then the next period to change benefits will be during open enrollment and submitted by the 25<sup>th</sup> of the month prior to renewal date.
4. Employee waiting periods are not to exceed 6 months.
5. New employees will be able to enroll in the plan on the first of the month following the plan's waiting period.
6. Employees who are terminated will be covered until the last day of the month in which the termination occurred. All terminations must be submitted either on a completed termination form or on company letterhead.
7. Late enrollees (those who decline coverage and subsequently wish to enroll without a qualifying event) will be eligible to enroll at the next annual open enrollment period. Qualifying events: unexpected event that will terminate an employee's participation in another health plan. An example of a qualifying event is loss of coverage thru a spouse losing a job.

## CASE INSTALLATION

1. **Small Group/Sole Proprietor Eligibility Sheet**
  - A. The group must be actively in business with a street address in one of the five Boroughs: Bronx, Brooklyn, Manhattan, Queens, or Staten Island.
  - B. Atlantis requires all enrolling subscribers to reside or work in the contracted area: Bronx, Brooklyn, Manhattan, Queens, or Staten Island
  - C. Full-time is defined as actively at work at least 20 hours per week and a group must have at least one full-time employee to remain active. ***Sole Proprietor/1099 cases must be submitted with a Schedule C or 1099.***
  - D. Owners, Partners and Officers must meet minimum hourly requirements. POS participation requirement is 50% participation after spousal waivers. There are no minimum requirements for HMO groups. Employees not electing coverage must submit a waiver form with case submission.
  - E. Medicare recipients are eligible as long as they meet the criteria in #1C.
  - F. Eligible dependents are defined as a legally married spouse or a legally dependent child up to the age of 19. Student rider up to age 23 is included in community rates if financially dependent and enrolled as a full-time student at an accredited educational institution. Riders to age 25 and age 29 are also available.
  - G. The following are excluded from eligibility and coverage:
    - a. Part-time employees (19 hours or less)
    - b. Seasonal workers & temporary personnel
    - c. Retirees
  - H. ***Should Atlantis Health Plan determine that group information is materially false, we reserve the right to terminate or deny coverage.***
2. **To enroll a new case, all completed documents must be submitted to Atlantis Health Plan no later than the fourth Monday of the month preceding the effective date.**
3. **Groups enrolling 5 or more employees are allowed 2 plan options. Only one tier structure is allowed.**

4. **All of the following information is required before processing**
- A. Social Security Number
  - B. Date(s) of birth for all individuals applying
  - C. Complete address
  - D. Date of marriage (if applicable)
  - E. Physician selection
  - F. Employment effective (start) date
  - G. Dependent information
  - H. Employer, as well as Employee, signature
  - I. All small group businesses must supply the following tax documentation to Atlantis Health Plan:
    - a. Most recent Quarterly Wage & Tax Statement: NYS 45
    - b. If not required to file Wage & Tax Statement, one of the following is required:
      - i. Business Type Requirements
        1. *If a "C" corporation:* Articles of incorporation, form 1120 (line 13 is wages) and payroll documents
        2. *If a Church:* Form 941 (line 2 is wages) and payroll documents
        3. *If an LLC:* LLC agreement and the appropriate documentation noted above
        4. *If a Partnership:* K-1 or Form 1065 (line 9 is wages) and payroll documents and business license
        5. *If an "S" corporation:* Articles of incorporation, form 1120S (line 8 is wages) and payroll documents
        6. *If a Sole Proprietor:* Business license, form 1040/Schedule C (line 26 is wages) and payroll documents
      - c. If the business has been in existence less than 1 year and has not yet filed a Quarterly Wage and Tax Statement, Atlantis Health Plan will accept Corporation or Partnership papers and payroll documents.

***Please note, incomplete applications will be returned and may affect the requested effective date.***

## 5. Required Documentation for Case Installation

- A. Group Agreement Form
- B. Sales Submission Form
- C. Check for 1<sup>st</sup> month premium from the employer's business account
- D. Fully completed original employee enrollment forms and waiver forms (if applicable). Faxes or copies are not acceptable
- E. Previous Insurance Coverage Form for all enrolling subscribers and dependents
- F. Quarterly wage and tax statements (NYS 45) for small groups and Schedule C/1099 tax documents for Sole Proprietors/1099 employers (See chart below for tax)
- G. Applicable Student Verification Form accompanied by original sealed document from educational institution
- H. Previous Insurance Coverage Form and copy of current carrier bill on small groups (if applicable)

## 6. Enrollment & Waiting Periods

- A. Groups are eligible for coverage on the 1<sup>st</sup> of the month only. We will accept 15<sup>th</sup> of the month effective dates only when an existing policy (effective 15<sup>th</sup> of the month) is in place.
- B. Open enrollment will be held once a year on the group's anniversary or renewal date.
- C. **PLAN CHANGES.** An official at the company should submit plan changes to Atlantis Health Plan no later than one month after initial enrollment. If no changes are made, the next period to change benefits will be during open enrollment.
- D. Employee waiting periods can be 0, 30, 60 and/or 90 days but may not exceed 6 months.
- E. New employees will be able to enroll in the plan on the first of the month following the plan's waiting period.
- F. Employees who are terminated will be covered until the last day of the month in which the termination occurred. All terminations must be submitted either on a completed termination form or on company letterhead.
- G. Those who decline coverage and subsequently wish to enroll without a qualifying event will only be eligible to enroll during the next annual open enrollment period.

***Qualifying Event: An unexpected event that will terminate an employee's participation in another health plan. An example of a qualifying event is the loss of coverage through a spouse losing a job.***



**REQUIRED DOCUMENTATION TO SUBMIT A CASE**

1. Group Agreement Form. ( )
2. Sales Submission Form. ( )
3. Check for 1<sup>st</sup> month premium from the employer's business account. ( )
4. Fully completed original employee enrollment forms and waiver forms (if applicable). Faxes or copies are not acceptable. ( )
5. Health History Coverage Form for all enrolling subscribers & dependents. ( )
6. Quarterly wage and tax statements (NYS 45) for small groups and Schedule C tax document for Sole Proprietors. See chart below for tax documents needed for other type businesses. ( )
7. Health History Coverage Form and copy of current carrier bill on small groups (if applicable). ( )

All small group businesses must supply the following tax documentation to Atlantis Health Plan:

1. Most recent Quarterly Wage & Tax statement: NYS 45.
2. If not required to file Wage & Tax Statement, one of the following is required:

Business Type	REQUIREMENTS
If a "C" corporation	Articles of incorporation, form 1120 (line 13 is wages) and Payroll Documents
If a Church	Form 941 (line 2 is wages) and payroll Documents
If an LLC	LLC agreement and the appropriate documentation noted above.
If a Partnership	K-1 or Form 1065 (line 9 is wages) and payroll documents and business license.
If an "S" corporation	Articles of incorporation, form 1120S (line 8 is wages) and payroll documents
If a sole proprietor	Business license, form 1040/Schedule C (line 26 is wages) and Payroll Documents

3. If the business has been in existence less than 1 year and has not yet filed a quarterly Wage and Tax Statement, Atlantis Health Plan will accept Corporation or Partnership papers and payroll documents.

# ATLANTIS HEALTH PLAN, INC.

## Group Agreement Form

Group Administrator: \_\_\_\_\_

Group Name: \_\_\_\_\_

Group Number: \_\_\_\_\_

Effective Date: \_\_\_\_\_

Tax ID #: \_\_\_\_\_

In consideration of the payment of Premiums in accordance with the terms and provisions of this Group Agreement Form, Atlantis Health Plan, Inc. ("Atlantis") shall hereby arrange or pay for medical and hospital services in accordance with the terms and provisions of the Subscriber Contract for Subscribers and their Covered Dependents ("Members"). Terms not defined herein shall have the meaning set forth in the Subscriber Contract.

### I. Effective Date and Term of Agreement:

This Agreement shall be effective on the \_\_\_\_\_ day of (month/year) \_\_\_\_\_ at 12:00 a.m. Eastern Time and will remain in effect for a period of \_\_\_\_\_ consecutive Months, ending on the \_\_\_\_\_ day of (month/year) \_\_\_\_\_ at 11:59 p.m. Eastern Time at which time coverage provided pursuant to the Subscriber Contract will be renewed automatically for one (1) year periods thereafter unless written notice of cancellation has been given by either party as set forth in Section XIII of this Agreement.

### II. Coverage - Plan Design:

Tier:       2       3       4

Plan:       HMO    HMO-Low    POS    POS-Low

Co-Pay:    \$10    \$15    \$20    \$25/\$40  
             \$10E    \$15E    \$20E    \$25/\$40E

Coinsurance:       70%       80%

Deductible:       \$300/\$750       \$1000/\$2500  
                       \$500/\$1250       \$2000/\$4000

### Riders:

- |   |   |
|---|---|
| <input type="radio"/> A \$10/20/30        | <input type="radio"/> O \$0/20/30                       |
| <input type="radio"/> B \$15/25/35        | <input type="radio"/> P \$0/30/50                       |
| <input type="radio"/> C \$20/30/40        | <input type="radio"/> Signature \$0/25/\$250 deductible |
| <input type="radio"/> D \$10/15/30        | <input type="radio"/> M-A Age 29                        |
| <input type="radio"/> E \$15/20/35        | <input type="radio"/> Vision-High                       |
| <input type="radio"/> F \$20/25/40        | <input type="radio"/> Vision-Low                        |
| <input type="radio"/> G \$7/30/50         | <input type="radio"/> 60 SNF                            |
| <input type="radio"/> H \$7/30/50/100     | <input type="radio"/> 40+MHOP                           |
| <input type="radio"/> I \$7/30/50/250     | <input type="radio"/> 30+MHIP                           |
| <input type="radio"/> J \$7/30/50/1000max | <input type="radio"/> Timothy's Law                     |
| <input type="radio"/> M Mandatory Generic | <input type="radio"/> Other: _____                      |

Hospital Co-Pay:       \$0       \$250       \$500

### III. Premium Rate Schedule

<u>Type of Coverage</u>	<u>Total Monthly Premium</u>
Single	\$ _____
Husband/Wife	\$ _____
Parent/Child(ren)	\$ _____
Family	\$ _____

### IV. Eligibility:

Eligible members must reside or live in the Service Area or work in the Area and receive all covered health care there. In addition, eligible subscribers and their eligible family members shall meet the eligibility criteria set forth in the Subscriber Contract. Coverage ends on the last day of the month premium covers.

\*Waiting Period \_\_\_\_\_ days/months from date of hire.  
(Eligible the first of the month following waiting period).

Subscriber (employee) coverage ends on the last day of the month that employment ends.

Family Members are spouse and dependent children until child reaches age 19, or age 23 if enrolled as a full-time student at an accredited educational institution. Coverage ends on the last day of the month in which the child's birthday occurs.

Eligibility will be restricted to an individual or small group where the individual or small group has had coverage terminated within the previous twelve (12) months for non-payment of premiums per Section 360.3(11) of Regulation 145.

### V. Notice:

Any notice hereunder to be given to Group Administrator shall be addressed to

Attn: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Telephone#: \_\_\_\_\_

Fax#: \_\_\_\_\_

E-mail: \_\_\_\_\_

Any notice hereunder to be given to Atlantis shall be addressed to:

**Atlantis Health Plan, Inc.**  
**45 Broadway, Suite 300**  
**New York, NY 10006**



## **VI. Premium Due Date and Payments:**

The first day of a month of coverage hereunder is the "Premium Due Date". The Group Administrator agrees to remit to Atlantis on or before the Premium Due Date the applicable Total Monthly Premium set forth in Section III above for each Subscriber and Covered Dependent enrolled as of such date as determined by Atlantis by reference to Atlantis member records. If such Premium payment is not made in full by Group on or prior to the Premium Due Date, a thirty (30) day Grace Period shall be granted to Group for payment without interest charge. If payment is not received by the expiration of the Grace Period, then Atlantis pursuant to Section XIII may terminate this Agreement.

If this Agreement is terminated for any reason, Group Administrator shall continue to be held liable for all Premium payments due and unpaid before termination, including, but not limited to, Premium payments for any time this Agreement is in force during the Grace Period. Notwithstanding any language to the contrary in this Agreement or the Subscriber Contract, Atlantis shall have no obligation to provide benefits or pay claims for any Member during any period for which the required Premium payment has not been made (except during any Grace Period). If Atlantis does provide benefits or pay claims for any Member during any period for which the Premium payment has not been made, such provision of benefits or payment of claims shall not constitute a waiver of Atlantis' rights to discontinue the provision of coverage or payment of claims until such time as the Premium payment is made.

## **VII. Premium Rate Changes:**

The Premium Rate Schedule set forth on page one of this Agreement shall be valid only for the Initial Contract Period. If Atlantis elects to offer coverage to the Group for any Subsequent Contract Period after the Initial Contract Period, Atlantis may change the Premium Rate Schedule for any Subsequent Contract Period. Atlantis will give Group at least forty-five (45) days advance notice of the Premium Rates for each Subsequent Contract Period. If Atlantis fails to give Group such forty-five (45) days advance notice, the Premium Rates in effect prior to the commencement of the Subsequent Contract Period shall remain in effect for a period of forty-five (45) days after the Group was notified by Atlantis of the new Premium Rates for the Subsequent Contract Period, after which period the new Premium Rates will go in to effect. Under no circumstances shall Atlantis' failure to provide forty-five (45) days advance notice of new Premium Rates obligate Atlantis to continue coverage for the Group beyond the end of the Initial Contract Period or a Subsequent Contract Period as the case may be. At any time, with a forty-five (45) day notice, Atlantis may change the premium schedule for any subsequent contract period when a change required by statute or regulation increases Atlantis' risk under the agreement.

## **VIII. Member Effective Dates of Coverage:**

Coverage of prospective Subscribers and Covered Dependents shall be subject to receipt by Atlantis of Enrollment Form for each prospective Subscriber and Covered Dependant within thirty-one (31) days of each Subscriber or Covered Dependant becoming eligible for coverage under this Agreement, together with receipt of the monthly Premium for such Subscriber or Covered Dependent as applicable.

## **IX. Ineligible Members:**

If, upon a Member becoming ineligible, Group Administrator fails to immediately notify Atlantis of such Member's termination, and Group Administrator has made or continues to make the Premium payment specified herein for such Member, such Premium payment will only be credited by Atlantis to Group back to the last day of the month immediately prior to the month in which such termination notice is received by Atlantis, provided Atlantis has not authorized or incurred claims for health services for such Members after such Member became ineligible, but before Atlantis received a proper disenrollment notification from the Group with respect to such Member's termination.

## **X. Annual Renewal**

The Group Administrator shall hold an annual renewal meeting at least once each year at which time the group and eligible members, as determined by this Agreement and the Subscriber Contract, may elect changes under this Agreement.

## **XI. Responsibilities of Group:**

Group agrees to:

- A. Offer coverage to eligible members and their family members, as described in Section IV above. It is understood that eligible members of a Group shall be free to choose either Atlantis coverage or such other coverage as may be available through the Group during both the initial and subsequent Group Open Enrollment Periods. Every eligible member of the Group shall be given a fair opportunity to elect one of such options over the other and shall not be penalized by the Group because of such a choice, other than through differential payroll deductions as may be indicated by premium variations from insurer to insurer.
- B. Offer each new member the opportunity to elect Atlantis coverage as a procedure of employment when such person attains the status of an eligible member as provided in this Agreement.
- C. Provide notification to each Member, within fifteen (15) days after termination of the Member's coverage, of the Member's right to convert to an Atlantis individual direct payment contract, and the duration of such conversion coverage.
- D. Furnish to Atlantis, on a monthly basis on Atlantis approved forms, such information as may reasonably be required by Atlantis for the administration of Atlantis' prepaid program and coverage provided hereunder, including any change in a Member's eligibility status. In addition, Atlantis may, at reasonable times, examine the group's administrator's pertinent records with respect to eligibility and premium payments hereunder. Per the employee's signature on the Atlantis enrollment application, the member agrees to allow the group to remit membership information to Atlantis Health Plan.
- E. Comply with all policies and procedures established by Atlantis in administering and interpreting this Agreement and communicated to Group Administrator by Atlantis.
- F. Furnish all Member enrollment and termination/change notification to Atlantis solely on Atlantis enrollment and termination forms within the time periods required by this Agreement.

## **XII. Termination:**

- A. Except as otherwise provided by applicable Law, this Agreement and the coverage provided hereunder may be terminated by Atlantis:
  1. In the event that the policyholder or a participating entity has failed to pay premiums or contributions in accordance with the terms of the contract as set forth in Section VI of this Agreement, or Atlantis has not received timely premium payments.
  2. In the event that the policyholder or a participating entity has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Contract, upon not less than one month's prior written notice.
  3. Upon discontinuance of this class of HMO contract upon not less than five (5) months' prior written notice. In exercising the option to discontinue coverage, Atlantis shall act uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for such coverage and shall give the option to purchase all other individual health insurance coverage currently being offered by Atlantis to applicants in that market.
  4. Upon discontinuance of all hospital, surgical or medical expense insurance contracts for which the premiums are paid by a

remitting agent of a group, in the small group market, or the large group market, or both markets, in this state. Written notice shall be given to the Superintendent and to each subscriber not less than one hundred eighty days (180) prior to the date of the expiration of such coverage. In the event of such a withdrawal, the Corporation must also provide the Superintendent with a written plan to minimize potential disruption in the marketplace occasioned by such withdrawal. In addition, Atlantis may not provide for the issuance of any hospital, surgical or medical expense coverage in such market in this state during the five-year period beginning on the date of the discontinuance of the last health insurance coverage not so renewed.

5. The policyholder ceases to meet the requirements for a group under Section 4235 of the Insurance law, or a participating employer, labor union, association or other entity ceases membership or participation in the group to which this Agreement is issued. Termination shall be done uniformly without regard to any health status-related factor relating to any covered individual.

6. Pursuant to this network Plan, there is no longer any enrollee in connection with such Plan who lives, resides or works in the Atlantis Service Area for which the corporation is authorized to do business.

7. Upon written notice, if the Group ceases to operate or relocates outside the Service Area; or

8. Such other reasons as the Superintendent may approve and authorized by the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and any later amendments or successor provisions, or by any federal regulations or rules that implement the provisions of the Act, upon not less than one month's prior written notice.

B. Except as otherwise provided by applicable Law, this Agreement and the coverage provided hereunder **may be terminated by the Group upon one month's prior written notice of termination.**

### **XIII. Amendments:**

Any amendments to this Agreement shall be in writing and must be approved and authorized by representatives of both the Group Administrator and Atlantis. No other individual has the authority to modify this Agreement, waive any of its provisions or restrictions, extend the time for making a payment, or bind Atlantis by making any other commitment or representation.

Formal acceptance of an amendment to this agreement by the Group Administrator shall not be required: if the change has been negotiated by means of a request by the Group Administrator and agreed to by Atlantis; if the change is required to bring the Agreement into conformance with any applicable law, regulation or ruling of the jurisdiction in which the Agreement is delivered-or of the federal government; or if the Group Administrator makes payment of any applicable Premium on or after the effective date of such amendment.

### **XIV. Entire Agreement:**

This Agreement, the Member Enrollment Application of each member, and the Subscriber Contract constitute the entire agreement between the parties and supersedes all prior and contemporaneous arrangements, understandings, negotiations and discussions of the parties with respect to the subject matter hereof, whether written or oral; and there are no warranties, representations, or other agreements between the parties in connection with the subject matter hereof, except as specifically set forth herein. No supplement, modification or waiver of this Agreement shall be binding unless executed in writing by authorized representatives of the parties.

### **XV. Applicable Law:**

The laws of the State of New York shall govern this agreement.

### **XVI. Inconsistency:**

In the event of any inconsistency between this Group Agreement Form and the Subscriber Contract, the terms of this Group Agreement Form shall govern.

### **Community Rates:**

New York State requires HMOs to charge Groups premium rates that are consistent from one Group of the same type to another. This concept is called Community Rating. Atlantis does not base the premium your Group is charged on the actual cost of providing services to your Group alone, but an average of all Groups which fit into the same category as yours. Atlantis may, of course charge different premiums for different benefit packages. Atlantis may also, if we so choose, develop premiums that vary by certain factors such as group size.

Because all HMOs are required to get approval by the New York State Department of Insurance for each benefit package and rider for a specific time period, the HMO is also required to charge and collect premiums equivalent to that approved rate. There are a number of factors, which could impact whether or not your Group is being charged the approved premium rate:

- Timing of Premium Rate Quote;
- The Period which the Premium Rate Quote is different than the community rating period;
- Rate adjustments required due to an over- or undercharge for a prior period.

**Group Information**

Authorized Signature: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Number of Full-Time Employees \_\_\_\_\_

Number of Part-Time Employees \_\_\_\_\_

Number of Employees Eligible for Health Insurance Benefits \_\_\_\_\_

**Broker/ Sales Agent Information**

1. Full legal name of firm/Agent: \_\_\_\_\_

2. Address of firm/Agent: \_\_\_\_\_

3. Contact: \_\_\_\_\_

4. Telephone No. \_\_\_\_\_

5. SS # or Fed. Tax ID# \_\_\_\_\_

6. Broker/Agent ID Codes: \_\_\_\_\_

**ATLANTIS HEALTH PLAN, INC.**

Authorized Signature: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

**General Agent Information**

1. Full legal name of firm: \_\_\_\_\_

2. Address of firm: \_\_\_\_\_

3. Contact: \_\_\_\_\_

4. Telephone No. \_\_\_\_\_

5. SS # or Fed. Tax ID# \_\_\_\_\_

6. GA ID Codes: \_\_\_\_\_

I acknowledge that my Atlantis Health Plan identification cards may not be received by the 1<sup>st</sup> day of my effective month. However, I understand that I will be covered the 1<sup>st</sup> day of my effective month.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

READ THE FOLLOWING STATEMENTS VERY CAREFULLY.

YOUR SIGNATURE(S) ON THIS PAGE INDICATE(S) THAT YOU HAVE READ, UNDERSTAND, AND AGREE TO ALL OF THE PROVISIONS SET FORTH ON THIS APPLICATION. PLEASE SIGN AND DATE.

- A. **Coverage Request:** I/We hereby request coverage of the type indicated in the attached application. If this request is for a family contract, the names of my spouse and eligible dependent children are listed. I make this application on their behalf as well as my own. If this request is accepted, coverage will be effective only if my payment of the subscription charge is paid in full to Atlantis Health Plan.
- B. **Statement of Fidelity:** I/We affirm that all attached documents, statements, and answers in this application are true and are representations made to induce the issuance of the contract applied for. If accepted, this application will be part of the contract. The contract will become effective on the date specified on the identification card or group contract. Any misrepresentation by me of facts which are material to this application may result in rescission of this contract.
- C. **Pre-Existing Conditions:** I/We understand that there will be an 11 month waiting period for benefits for any physical or mental condition, regardless of the cause, for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on my/our enrollment date for this coverage. Credit for prior creditable coverage will be applied to this waiting period if such coverage was continuous to a date not more than 63 days prior to my/our enrollment date for this coverage. In the case of previous health insurance coverage, any affiliation period prior to that previous coverage becoming effective will also be credited. Upon request, I/we must provide appropriate documentation of prior coverage to Atlantis Health Plan.
- D. **Privacy Statement:** I/We authorize any health care provider, payer of health and health related claims, or government agency to furnish to Atlantis Health Plan or its designee all records pertaining to medical history, services rendered, and payments made regarding me or my dependents for review and evaluation of any claim, or services in conjunction with managed care. I/We authorize Atlantis Health Plan to disclose such information to my/our physician; another payer or self-insurer, and if my/our coverage is under a group contract held by an employer, association, trust fund, or similar entity, to the group contract holder, or to an Atlantis Health Plan designee for purposes of continuity of care and medical management, disease management, managed disability coordination or financial audits.
- E. **Effective Date:** I/We acknowledge that the effective date stated on the attached agreement is in effect upon approval of the underwriting department. Although membership identification cards may not be issued by the effective date of the policy, if they are received within 30 days of the said effective date then no change to the agreed upon effective date will occur.
- F. **Voluntary Termination:** If this coverage is issued, I/we may make a written request to cancel the contract within 10 days after receipt. I/we understand that any medical services rendered during this time will not be covered. Thereafter, I/we understand that 30 days advance written notification to Atlantis Health Plan is required to terminate coverage.

All statements and answers in this application are true, and are representations made to induce the insurance of coverage. Any misrepresentation of material fact may result in cancellation or rescission of coverage.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purposes of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. I have read, understand, and agree to all the provisions set forth.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Spouse's Signature \_\_\_\_\_

Date \_\_\_\_\_



# PREVIOUS INSURANCE COVERAGE FORM

**Subscriber:** To complete the enrollment process, information on any prior health insurance coverage you and/or your dependents have had in the last 12 months is required. Please attach the "Certificate of Coverage" from your prior health plan(s) or complete the following.

Within the last 12 months I have had: *(check one)*

No Prior Coverage       One Insurance Carrier       Multiple Insurance Carriers

<b>Subscriber Insurance Carrier Name:</b>	Policy/Subscriber Number:	
Date Coverage Began:	Date Coverage Ended:	
Type of Policy:	<input type="checkbox"/> Group	<input type="checkbox"/> Direct Payment
Coverage Type:	<input type="checkbox"/> Family	<input type="checkbox"/> Individual
<b>Spouse Insurance Carrier Name:</b>	Policy/Subscriber Number:	
Date Coverage Began:	Date Coverage Ended:	
Type of Policy:	<input type="checkbox"/> Group	<input type="checkbox"/> Direct Payment
Coverage Type:	<input type="checkbox"/> Family	<input type="checkbox"/> Individual
<b>Dependent Insurance Carrier Name:</b>	Policy/Subscriber Number:	
Date Coverage Began:	Date Coverage Ended:	
Type of Policy:	<input type="checkbox"/> Group	<input type="checkbox"/> Direct Payment
Coverage Type:	<input type="checkbox"/> Family	<input type="checkbox"/> Individual
<b>Dependent Insurance Carrier Name:</b>	Policy/Subscriber Number:	
Date Coverage Began:	Date Coverage Ended:	
Type of Policy:	<input type="checkbox"/> Group	<input type="checkbox"/> Direct Payment
Coverage Type:	<input type="checkbox"/> Family	<input type="checkbox"/> Individual

If additional space is needed for dependents, please complete a separate sheet of paper.

To the best of my knowledge, the information provided above is true and complete. I understand that failure to complete this form may result in denied claim payment for services.

Print Name of Subscriber

Signature of Subscriber

Date

## Notice of Enrollment Period and Waiver Form

Employer Group Name: \_\_\_\_\_

If you are declining enrollment for yourself and/or dependents (including your spouse) under this plan because you have other health coverage, you may in the future be able to enroll yourself or your dependents in this plan. Your request for enrollment must be submitted to Atlantis Health Plan within 30 days after your other coverage involuntarily ends.

If you are declining coverage, please check one of the following reasons:

- \_\_\_\_\_ **I am declining coverage because I have coverage through my spouse.**
- \_\_\_\_\_ **I am declining coverage because I am enrolling in another coverage option offered by my employer.**
- \_\_\_\_\_ **I am declining coverage because I choose not to participate. I understand that I will not be eligible to enroll in this plan until the open enrollment date.**

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

**CREDIT CARD/DEBIT CARD PAYMENT AUTHORIZATION**

I AUTHORIZE ATLANTIS HEALTH PLAN TO BILL MY CREDIT/DEBIT CARD ACCOUNT INDICATED BELOW FOR PAYMENT OF PREMIUM CHARGES. I UNDERSTAND THAT MY PREMIUM MAY CHANGE UPON ANNUAL RENEWAL AND GIVE PERMISSION TO ADJUST PAYMENT ACCORDINGLY. I UNDERSTAND AND AGREE THAT BY EXECUTING THIS AUTHORIZATION, THIS ACTION DOESN'T AFFECT, WAIVE, OR CHANGE ANY OF THE POLICY'S TERMS, CONDITIONS, AND PROVISIONS, INCLUDING THE POLICY'S PREMIUM PAYMENT AND GRACE PERIOD PROVISIONS.

PRINT NAME AS IT APPEARS ON CREDIT/DEBIT CARD \_\_\_\_\_

BILLING ADDRESS \_\_\_\_\_

How to Locate Your Security Code

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

SELECT ONE: ( ) VISA ( ) MASTERCARD ( ) AMERICAN EXPRESS



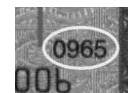
Visa, MasterCard

CREDIT/DEBIT CARD NUMBER \_\_\_\_\_ / \_\_\_\_\_  
CARD EXPIRATION DATE

MUST CHOOSE AT LEAST ONE: ONE TIME ONLY \$ \_\_\_\_\_ Security code

MONTHLY AUTOMATIC (RECURRING) PAYMENT \$ \_\_\_\_\_

ATLANTIS ACCOUNT # (GROUP ID/MEMBER ID): \_\_\_\_\_



American Express

AUTHORIZED SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**BANK DRAFT (ACH) PAYMENT AUTHORIZATION**

I HEREBY AUTHORIZE ATLANTIS HEALTH PLAN TO INITIATE MONTHLY DEBIT ENTRIES TO MY CHECKING/SAVINGS ACCOUNT. I UNDERSTAND THAT MY PREMIUM MAY CHANGE UPON ANNUAL RENEWAL AND GIVE PERMISSION TO ADJUST PAYMENT ACCORDINGLY. I UNDERSTAND AND AGREE THAT BY EXECUTING THIS AUTHORIZATION, THIS ACTION DOESN'T AFFECT, WAIVE, OR CHANGE ANY OF THE POLICY'S TERMS, CONDITIONS, AND PROVISIONS, INCLUDING THE POLICY'S PREMIUM PAYMENT AND GRACE PERIOD PROVISIONS

**ACCOUNT HOLDER INFORMATION**

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_  
(AS IT APPEARS ON YOUR ACCOUNT)

MAILING ADDRESS \_\_\_\_\_  
(AS IT APPEARS ON YOUR ACCOUNT)

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ -- \_\_\_\_\_

MUST CHOOSE AT LEAST ONE: ONE TIME ONLY \$ \_\_\_\_\_

MONTHLY AUTOMATIC (RECURRING) PAYMENT \$ \_\_\_\_\_

ATLANTIS ACCOUNT # (GROUP ID/MEMBER ID): \_\_\_\_\_

AUTHORIZED SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**FINANCIAL INSTITUTION INFORMATION**

INSTITUTION NAME \_\_\_\_\_ BRANCH LOCATION \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ - \_\_\_\_\_

ROUTING NUMBER \_\_\_\_\_ ACCOUNT NUMBER \_\_\_\_\_

CHECK ONE: SAVINGS ACCOUNT \_\_\_\_\_ CHECKING ACCOUNT \_\_\_\_\_

**PLEASE MAKE A NOTE ITEMS RETURNED FOR INSUFFICIENT FUNDS WILL BE ASSESSED A \$30 PENALTY FEE.** AUTHORIZATION WILL REMAIN IN FULL FORCE AND EFFECT UNTIL ATLANTIS HAS RECEIVED WRITTEN NOTIFICATION FROM THE ACCOUNT HOLDER TO TERMINATE, IN SUCH TIME AND IN SUCH MANNER AS TO AFFORD ATLANTIS A REASONABLE OPPORTUNITY TO ACT ON IT.

**YOU CAN FAX YOUR AUTHORIZATION TO 732-393-7200, ATTN: BILLING & ENROLLMENT OR  
MAIL TO: ATLANTIS HEALTH PLAN 90 MATAWAN ROAD, SUITE 204, MATAWAN NJ 07747**

**FOR NEW YORK STATE EMPLOYERS**

Section 217 of the New York State Labor Law requires that you inform your employees of any plan to terminate their health care coverage. The law requires that a notice from you explaining the reason for the termination be either (1) hand delivered at the place of employment (e.g., by including the notice in the employees' pay envelopes); or (2) mailed to the employees' last known residential address. You must also post a copy of the notice of intent to terminate and the required covering letter in a conspicuous location. These actions must be taken at least nine days prior to the intended termination date.

The law does not apply if, at least 10 days prior to the date of the intended termination, you have (1) taken necessary steps to render an Atlantis notice of termination null and void, such as mailing the required premium; or (2) contracted with another insurer for similar coverage for the same certificate holders, and filed an affidavit with the Commissioner of Labor and Superintendent of Insurance to that effect.