Account Membership Information and Attestation Form (Renewal)

Please check the appropriate box for the type of business entity:

☐ Small Business **(1 – 100 Full-Time Equivalent Employees)** ☐ Other, please explain ___________________________

Association / Chamber / Other Employer Organization name: ____

Business Name: ____ Tax ID #: ________________________________

Address: ____

City: ____ State: _______ Zip: ____________________________________

Contact Name: ____ Phone #: _______________________________

Email Address: ____ Fax #: _________________________________

Total # of full-time equivalent (FTE) employees: ______ (must be between 1 and 100 over the previous calendar year)
Total # of Employees: ____________ (used for MSP reporting purposes; not to determine account size)

More information about group size definition can be found on the Department of Financial Services website http://www.dfs.ny.gov/insurance/health/faqs_sm_grp_expansion_1to100.htm.

I certify that all the information furnished on this form is current, true and complete to the best of my knowledge and I have read and agreed to this statement and that I have authority to sign on behalf of the above named group. This application cannot be processed without a Tax Identification number. I understand that this form is being used as part of an application for health insurance and that 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 purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and subject to a civil penalty not to exceed $5,000 and that stated value of the claim for each such violation. I understand that Independent Health, reserves the right to request additional information prior to approving my application for insurance. I understand that Independent Health will conduct annual audits to ensure compliance with enrollment guidelines which may require us to provide verification of our being a bona fide employer. I understand that all subscribers must be employed a minimum of 17.5 hours per week in order to qualify for benefits under this contract.

Account Administrator's Signature: ____ Date: ____________________

Account Administrator's Name (print): ______________________________________ Title: ____________________

For Multi-employer/Multiple Employer Group Health Plan Use Only

I certify that the above group is a Member of ___________________________________. I understand that Independent Health will conduct annual audits to ensure compliance with enrollment guidelines which will include verification that the above group is still an active member in the Multi-employer/Multiple Employer Group Health Plan.

Authorized Signature: ____ Date: ____________________

Printed Name: ____ Title: ____________________

Please Fax the completed form to (716) 250-7125 **OR** email to: Sales.Administration@Independenthealth.com