Independent Health

Account Membership Information and Attestation Form (New Group)

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: Bar Association of Erie County

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)

Required Tax Documentation (To be returned with this form):

a) Most recent NYS-45
b) Corporation – most recent K-1 to Form 1120S or Schedule F; or Form 1120, followed by a **NYS45-ATT-MN upon receipt**
c) Partnerships – most recent 1065K-1 for each partner
d) New Business – SS4 (application for employer identification number) along with articles or certification of incorporation and a copy of the payroll listing or W4 for each employee. New partnerships may submit a Partnership Agreement and a W4 for each employee.
e) New employees not yet showing on **NYS-45 -** W4 form and/or a copy of their payroll check stub
f) Tax exempt entities – payroll records or W4 with a letter from company's accountant listing all employees

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): Christine Clapp Title: Plan Director

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