



**Account Membership Information and Attestation Form**

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: Trustees of the Erie County Bar Association

Business Name: \_\_\_\_\_ Tax ID #: \_\_\_\_\_

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

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

Contact Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Email Address: \_\_\_\_\_ Fax #: \_\_\_\_\_

Total # of Full-Time Equivalent Employees: \_\_\_\_\_

**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. Proprietorship – Schedule C, F or W2's
- e. 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.
- f. New employees not yet showing on NYS-45 - W4 form and/or a copy of their payroll check stub
- g. Tax exempt entities – payroll records or W4 with a letter from company's accountant listing all employees

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 Trustees of the Erie County Bar Assn. (Multi-employer / Multiple Employer Group Health Plan Name).

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: Christine Clapp Title: \_\_\_\_\_