



511 Farber Lakes Drive  
 Buffalo, NY 14221  
 1-800-453-1910  
 www.independenthealth.com

## Chamber of Commerce and Professional Association

**1. Please check one:**  GROUP ENROLLMENT APPLICATION  CHANGE FORM  COBRA ELECTION  
**2. EFFECTIVE DATE** \_\_\_\_/\_\_\_\_/\_\_\_\_ **GROUP #** \_\_\_\_ **PLAN #** \_\_\_\_  
 (Add, Change or Cancellation) (Please Reference Benefit Summary)

*Change Only / Please check all that apply:*  
 PLAN CHANGE  PHYSICIAN CHANGE  
 NAME CHANGE  ADDRESS CHANGE  
 ADD DEPENDENT / QUALIFYING EVENT (birth, marriage, etc.)  
*Reason codes on reverse side:*  
 CANCEL POLICY / Reason code \_\_\_\_  
 REMOVE DEPENDENT / Reason code \_\_\_\_  
 DEPENDENT ID # \_\_\_\_

**3. PLEASE PRINT AND RETURN TO YOUR EMPLOYER UPON COMPLETION.**  
**THANK YOU FOR CHOOSING INDEPENDENT HEALTH.**

**8. EMPLOYER ATTESTATION (employer must complete this section)**  
 EMPLOYER NAME \_\_\_\_\_ CITY \_\_\_\_\_ COUNTY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP + 4 \_\_\_\_\_  
 EMPLOYER ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ COUNTY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP + 4 \_\_\_\_\_  
 EMPLOYER TELEPHONE \_\_\_\_\_ EMPLOYER TAX ID \_\_\_\_\_  
 DATE JOINED CHAMBER/ASSOCIATION \_\_\_\_\_ DATE OF EMPLOYMENT \_\_\_\_\_  
 IS APPLICANT CURRENTLY WORKING AT LEAST 17.5 HOURS/WEEK?  Yes  No  
 WAS APPLICANT GIVEN A CHOICE OF HEALTH PLANS?  Yes  No  
 EMPLOYER SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Chamber/Association  
 Initials  
 REQUIRED FOR  
 PROCESSING

Initials \_\_\_\_\_  
 Today's Date \_\_\_\_\_

APPLICANT'S LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_  
 ADDRESS (NUMBER, STREET, APARTMENT) \_\_\_\_\_  
 CITY \_\_\_\_\_ COUNTY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP + 4 \_\_\_\_\_  
 TELEPHONE \_\_\_\_\_  
 HOME: ( ) \_\_\_\_\_ WORK: ( ) \_\_\_\_\_ EMAIL \_\_\_\_\_  
 HAVE YOU EVER BEEN A MEMBER OF INDEPENDENT HEALTH?  
 YES If yes, list your identification number \_\_\_\_\_  
 NO  
 WHAT IS YOUR PRIMARY LANGUAGE? \_\_\_\_\_  
 MALE  FEMALE GENDER  
 PRIORITY HEALTH INSURANCE: Prior coverage for previous 12 months: \_\_\_\_\_  
 FROM: \_\_\_\_\_ TO: \_\_\_\_\_  
 (Please provide detail on reverse side.)

APPLICANT	LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP	IH PHYSICIAN NUMBER (or full name and address)	CURRENT PAYMENT YES/NO	IH USE ONLY PHYSICIAN NUMBER
APPLICANT						Code * <input type="checkbox"/> HUSBAND <input type="checkbox"/> WIFE Code * <input type="checkbox"/> Daughter <input type="checkbox"/> Son Code * <input type="checkbox"/> Daughter <input type="checkbox"/> Son Code * <input type="checkbox"/> Daughter <input type="checkbox"/> Son Code * <input type="checkbox"/> Daughter <input type="checkbox"/> Son Code * <input type="checkbox"/> Daughter <input type="checkbox"/> Son			
SPOUSE						Code * <input type="checkbox"/> HUSBAND <input type="checkbox"/> WIFE Code * <input type="checkbox"/> Daughter <input type="checkbox"/> Son Code * <input type="checkbox"/> Daughter <input type="checkbox"/> Son Code * <input type="checkbox"/> Daughter <input type="checkbox"/> Son			
CHILD						Code * <input type="checkbox"/> Daughter <input type="checkbox"/> Son Code * <input type="checkbox"/> Daughter <input type="checkbox"/> Son Code * <input type="checkbox"/> Daughter <input type="checkbox"/> Son			
CHILD						Code * <input type="checkbox"/> Daughter <input type="checkbox"/> Son Code * <input type="checkbox"/> Daughter <input type="checkbox"/> Son Code * <input type="checkbox"/> Daughter <input type="checkbox"/> Son			
CHILD						Code * <input type="checkbox"/> Daughter <input type="checkbox"/> Son Code * <input type="checkbox"/> Daughter <input type="checkbox"/> Son Code * <input type="checkbox"/> Daughter <input type="checkbox"/> Son			

**4. Member Information:**

APPLICANT'S LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_  
 ADDRESS (NUMBER, STREET, APARTMENT) \_\_\_\_\_  
 CITY \_\_\_\_\_ COUNTY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP + 4 \_\_\_\_\_  
 TELEPHONE \_\_\_\_\_  
 HOME: ( ) \_\_\_\_\_ WORK: ( ) \_\_\_\_\_ EMAIL \_\_\_\_\_  
 HAVE YOU EVER BEEN A MEMBER OF INDEPENDENT HEALTH?  
 YES If yes, list your identification number \_\_\_\_\_  
 NO  
 WHAT IS YOUR PRIMARY LANGUAGE? \_\_\_\_\_  
 MALE  FEMALE GENDER  
 PRIORITY HEALTH INSURANCE: Prior coverage for previous 12 months: \_\_\_\_\_  
 FROM: \_\_\_\_\_ TO: \_\_\_\_\_  
 (Please provide detail on reverse side.)

**5. While enrolled in Independent Health, will you or your dependent(s) be covered by any of the following:** If additional space is required, please attach a separate sheet.

CHECK YES OR NO: LAST NAME OF POLICY HOLDER FIRST MI  
 \* MEDICARE  Yes (Please list all covered members) \_\_\_\_\_  
 No  
 \* OTHER HEALTH INSURANCE\* LAST NAME OF POLICY HOLDER FIRST MI  
 Yes (Please list all covered members) \_\_\_\_\_  
 No  
 \*including no fault and/or workers' compensation (in the event of an injury).

**6. Is your child (or children) a full-time college student?**  Yes  No  
**If yes, please complete section on back of application.**

**7. AUTHORIZATION: I have read and agree to the authorization on the reverse side of this form.**

**ALL SECTIONS MUST BE COMPLETED BEFORE PROCESSING. SUBSCRIBER'S SIGNATURE:** \_\_\_\_\_ DATE: \_\_\_\_\_

**IH USE ONLY** Effective Date: \_\_\_\_\_ Pre Ex \_\_\_\_\_ Group Number \_\_\_\_\_ Account Number \_\_\_\_\_ Tier Code \_\_\_\_\_ Benefit Package Code \_\_\_\_\_



**CHAMBER OF COMMERCE / ASSOCIATION  
GROUP MEMBERSHIP INFORMATION FORM**

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

- Sole proprietor (Group of One)  Partnership/Corp.  Small Business (2-50 employees)  
 Large Business (51 or more employees)  Other, please explain \_\_\_\_\_

Applicant Name \_\_\_\_\_ ID# \_\_\_\_\_

Chamber / Association Name \_\_\_\_\_ Group# \_\_\_\_\_

Business Name \_\_\_\_\_

Contact Name \_\_\_\_\_ Telephone \_\_\_\_\_

Business Address \_\_\_\_\_

Tax ID # \_\_\_\_\_ Date Business joined chamber/Assoc. \_\_\_\_\_

Number of employees eligible for health coverage through this employer \_\_\_\_\_

Total # of employees working at least 17.5 hours per week (20 hours for Sole Proprietors) \_\_\_\_\_

In order to verify the eligibility of our Independent Health subscribers we require the following information to be included with each application:

1. Business validation information.

- Copy of Doing Business As (DBA) certificate or state license or Federal Tax ID number.
- Copy of Schedule C for 2006 tax return or 2007 Estimated Schedule C.

Partnerships provide all of the following:

- Federal Tax ID number or copy of current Partnership Agreement
- Copy of 2006 Schedule 1065 K-1 or 2007 Estimated Schedule 1065 K-1.

Incorporated businesses provide all of the following:

- Federal Tax ID number or Articles of Incorporation or Federal 941 report or initial for SS4.
- Copy of 2006 Corporate Tax Return (1120C, 1120E, 1120S or Schedule E)-Income & Expense page(s) only or 2007 Estimated Corporate Tax Return Income & Expense information only.

2. Employee information.

- Groups of 2 or more eligible employees:  
Provide a copy of the last NYS-45 or 45 ATT form filed for all employees.

Individual employees:

- Provide Schedule C or Schedule E as required above or a copy of 2006 W-2 or 2006 Form 1099.

By signing below, the employer group or sole proprietor has read the following:  
I certify that all information furnished hereon is true and complete to the best of my knowledge. I understand that the Association/Chamber, in conjunction with 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 or sole proprietor. I understand that all subscribers must be employed a minimum of 17.5 hours per week (20 hours for sole proprietors) in order to qualify for benefits under this contract. If self-employed, I certify that my main source of income is the result of my self-employed status.

Employer Signature \_\_\_\_\_ Date \_\_\_\_\_

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