

The Peconic Bay Business Association

860 East Main Street
Riverhead, NY 11901
Tel: 631-369-0888 Fax: 631-369-4438



Application Instructions

- Complete PBBA membership form
- Complete group enrollment form; Section 1 – 8
- Complete “Transaction Form for Group Accounts”; pages 1-2
- Complete HSA Banking form; (if applicable)
- Check made payable to PBBA in the amount of \$35.00 for the yearly PBBA membership dues
- First Month’s Premium- Please attach a Business Check for the first month’s premium, payable to: PBBA.
- Check in the amount of \$50.00 made payable to “First HSA” to initially fund your HSA bank account (only if choosing an HSA account);
- Domestic Partners must submit the following two forms, both of which must be notarized (only if applicable)
 - A copy of the domestic partner registration form if the partners reside in a jurisdiction that provides registration (e.g., New York City). If the partners do not live in such a jurisdiction, then the Alternative Affidavit of Domestic Partnership form must be submitted.
 - The Declaration of Cohabitation & Financial Interdependence Form (DCIFIF). In addition, the partners must also provide three documents showing a similar residence and financial interdependence. The specific list of acceptable documents is shown on the Declaration of Cohabitation & Financial Interdependence Form.
- Tax Documents- *subject to change according to EmblemHealth’s underwriters.* Applicant must work a minimum of 20 hours per week and must provide one of the following document combinations to verify sole proprietor status:
 - Form 1040 and Schedule C – Coverage will be issued in the name of the company on this schedule;
 - Form 1120-S – U.S. Corporation Income Tax Return for S corporations with K-1(s);
 - Form 1065 with Schedule K-1;
 - Form 1040 and CT-4-S – New York S Corporation Franchise Tax Return;
 - Form 1040 and Schedule F – Profit and Loss from Farming;
 - Form 1040 and Schedule SE – Self-Employment Tax Form;
 - Articles of Incorporation or Certificate to Do Business and Letter of Certification signed by a CPA or Attorney who is not an employee or relative of an employee of the group.
- Effective Date:
EmblemHealth PBBA plans are only written for the first of each month.

PBBA is not responsible for changes made by the carrier. All subject to carrier approval.

****ALL PAPERWORK MUST BE RECEIVED IN OUR OFFICE – 15 DAYS PRIOR TO THE REQUESTED EFFECTIVE DATE.**



**PBBA Peconic Bay Business Association
Membership Application**

1) Name of Business _____

Nature of Business _____

2) Name of Contact Person _____

3) Address _____

(please incl both a physical address & PO Box if applicable) _____

4) Phone # _____

5) Fax # _____

6) Email Address _____

7) Are You Applying for Medical Benefits? YES () NO ()

PLEASE CIRCLE YOUR DESIRED PLAN

Emblem Health Insurance EPO \$5K/\$10K Deductible EPO \$10K/\$20K Deductible
EPO \$2500/\$5K Deductible w/ Co-insurance

8) Name of Insured _____

9) Insured's Social Security No. _____

10) Date of Birth _____

I the undersigned would like to apply for membership in the Peconic Bay Business Association. Enclosed is my check for the annual dues, payable to: "PBBA", in the amount of \$35.

Signature of Member **X** _____ **Date** _____

Print Name _____



TRANSACTION FORM FOR GROUP ACCOUNTS
 MEMBERSHIP/P.O. BOX 2820 • NEW YORK, NY 10116-2820
 (Please read important information on back before completing this form)
 Employers: See back for sections you must complete
PLEASE PRINT CLEARLY

INTERNAL USE ONLY
 CONTROL NUMBER

I. SUBSCRIBER INFORMATION										
LAST NAME		FIRST NAME			M.I.	TELEPHONE NUMBERS HOME WORK		EMAIL ADDRESS		
HOME ADDRESS		APT. NO.	SOCIAL SECURITY NUMBER (REQUIRED)			GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female		MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other _____		
CITY			STATE	ZIP CODE		PRIMARY LANGUAGE SPOKEN				

II. ENROLLMENT INFORMATION											
LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH MO/DAY/YR	SOCIAL SECURITY NUMBER (REQUIRED)	GENDER	RELATIONSHIP	MAILING ADDRESS (If different from above)	Required for EH CompreHealth		ADD ✓	DELETE ✓
								PRIMARY CARE PHYSICIAN ID Number	OB/GYN SELECTION ID Number		
SUBSCRIBER						SELF					
SPOUSE											
DEPENDENT											
DEPENDENT											
DEPENDENT											

III. OTHER CARRIER INFORMATION Do you or any of your dependents have other health care coverage? <input type="checkbox"/> Yes Please complete this section <input type="checkbox"/> No GO TO SECTION IV										
NAME OF SUBSCRIBER'S OTHER INSURANCE CARRIER		INSURANCE CO. PHONE #	TYPE OF CONTRACT <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Family		NAME OF POLICYHOLDER: LAST NAME FIRST NAME M.I.			POLICY ID. NUMBER	EFFECTIVE DATE	
NAME OF SPOUSE'S OTHER INSURANCE CARRIER/MEDICARE		INSURANCE CO. PHONE #	TYPE OF CONTRACT <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Family		NAME OF POLICYHOLDER: LAST NAME FIRST NAME M.I.			POLICY ID. NUMBER	EFFECTIVE DATE	

IV. DID YOU HAVE PRIOR HEALTH COVERAGE? <input type="checkbox"/> YES Please provide a 12-month history of all coverage in this section (Use additional pages if you need more space) <input type="checkbox"/> NO GO TO SECTION V							
NAME AND ADDRESS OF INSURER		TELEPHONE NUMBER OF INSURER	NAME OF POLICYHOLDER		POLICY I.D. NUMBER	EFFECTIVE DATE OF CURRENT OR PRIOR POLICY	TERMINATION DATE OF CURRENT OR PRIOR POLICY

V. PRE-EXISTING CONDITIONS

Pre-existing conditions will not be covered during the first twelve (12) months of enrollment in the EmblemHealth CompreHealth program or during the first eleven (11) months of enrollment in the EmblemHealth EPO, EmblemHealth PPO, EmblemHealth InBalance EPO, EmblemHealth InBalance PPO, EmblemHealth ConsumerDirect PPO or EmblemHealth ConsumerDirect EPO. A pre-existing condition is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice or treatment was recommended or received during the six (6) month period prior to your enrollment date. EmblemHealth will credit the time you were covered by prior creditable health insurance coverage toward the twelve (12) month or eleven (11) month period, as long as the break in coverage between the prior coverage and your EmblemHealth coverage does not exceed sixty-three (63) days, exclusive of any waiting periods. If requested, you or your group must provide EmblemHealth with information about your pre-existing conditions and/or previous coverage. You have the right to request a certificate of creditable coverage from your prior health plan. If needed, EmblemHealth will help you get such a certificate from your prior plan.

A large group (51 or more eligible employees) may elect to cover pre-existing conditions from the start of your EmblemHealth coverage. In such a case, your EmblemHealth policy will not contain a pre-existing condition limitation or it will state that the pre-existing condition limitation does not apply.

Please call EmblemHealth at 1-877-VIA-EMBLEM (1-877-842-3625) for more information about the pre-existing condition limitation.

VI. SUBSCRIBER AUTHORIZATION	
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 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.	
If I am required to contribute to the premium for my coverage, I hereby authorize my employer to deduct such contributions in advance from wages due me and to remit same to EmblemHealth.	
Your signature is required to process this form. Your signature attests that you have read the above, and the reverse side of this form.	
_____	_____
Applicant must sign here	Date

VII. EMPLOYER INFORMATION - TO BE COMPLETED BY EMPLOYER (SMALL GROUP EMPLOYERS MUST READ AND COMPLETE SECTION BELOW)

SUBSCRIBER EMPLOYMENT STATUS			EMPLOYEE WAITING PERIOD		
<input type="checkbox"/> Employed	<input type="checkbox"/> Not Employed	<input type="checkbox"/> Retired	<input type="checkbox"/> COBRA: <input type="checkbox"/> 18 mo. <input type="checkbox"/> 36 mo.	<input type="checkbox"/> Retiree/RDS - Effective Date _____	<input type="checkbox"/> YES NUMBER OF WAITING PERIOD DAYS _____
				<input type="checkbox"/> NOT APPLICABLE	NUMBER OF ACTIVE EMPLOYEES IN YOUR GROUP _____
Check one: <input type="checkbox"/> New Enrollment <input type="checkbox"/> Reinstatement <input type="checkbox"/> Termination <input type="checkbox"/> Change to Individual Policy STATUS CHANGE: <input type="checkbox"/> Add Dependent <input type="checkbox"/> Remove Dependent <input type="checkbox"/> Address Change <input type="checkbox"/> Name Change Reason for Change: _____ TRANSFER: <input type="checkbox"/> To Another Carrier <input type="checkbox"/> EmblemHealth Group # Change: From _____ To _____ Is applicant currently working at least 20 hours per week? <input type="checkbox"/> Yes <input type="checkbox"/> No					
NAME OF GROUP		GROUP NUMBER: MED/HOSPITAL: DENTAL		SELECT ONE: <input type="checkbox"/> EmblemHealth CompreHealth (small groups only) <input type="checkbox"/> EmblemHealth PPO <input type="checkbox"/> EmblemHealth ConsumerDirect PPO <input type="checkbox"/> EmblemHealth CompreHealth EPO (large groups only) <input type="checkbox"/> EmblemHealth InBalance EPO <input type="checkbox"/> EmblemHealth ConsumerDirect EPO <input type="checkbox"/> EmblemHealth EPO <input type="checkbox"/> EmblemHealth InBalance PPO	
REQUESTED EFFECTIVE DATE MEDICAL: _____ DENTAL: _____		HIRE DATE	DATE SUBMITTED TO EMBLEMHEALTH	APPROVED BY (Group Plan Administrator)/Title	TYPE OF COVERAGE: <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> FAMILY <input type="checkbox"/> EMPLOYEE & SPOUSE <input type="checkbox"/> EMPLOYEE & CHILD

Instructions to Group Plan Administrator: For Groups with 50 employees or less, you **MUST** complete the following documentation section. Required documentation **MUST** be attached to this Transaction Form to be processed.

DOCUMENTATION BASED ON GROUP SIZE (To be completed by Small Group Plan Administrator)					
ACTION Check (✓) One	Qualifying Event	Group Type (Check One) Documentation Required	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Sole Proprietorship or One Subscriber Group	Association of Two or More Employees	Small Group - Less Than 50 Employees
<input type="checkbox"/> Add Subscriber	New Hire or Change in Plan	For eligible employees who work more than 20 hours weekly, provide a recent copy of NYS45 showing this subscriber as an employee or copy of payroll documentation reflecting the date, employee's name and Social Security # or the employee's current year W4 form.	Not Eligible		
<input type="checkbox"/> Add Spouse	Marriage Court Order	<input type="checkbox"/> Marriage Certificate <input type="checkbox"/> Court Order			
<input type="checkbox"/> Add Dependent	Birth Adoption Court Order	<input type="checkbox"/> Birth Certificate or <input type="checkbox"/> Formal Adoption Papers or <input type="checkbox"/> Court Approved Guardianship Papers or <input type="checkbox"/> Court Order			
<input type="checkbox"/> Add Spouse <input type="checkbox"/> Add Dependent	Loss of Coverage	Certificate of Creditable Coverage			

Note: No retroactive enrollments will be allowed. Members must be enrolled within 30 days from the qualifying event.

FOR EMBLEMHEALTH USE ONLY		
PROCESSED BY	RECEIVED DATE	PROCESSED DATE

IMPORTANT INFORMATION

1. The subscriber must complete sections I through VI. The group plan administrator must complete section VII, and, if for a small group, the documentation section above.
2. All effective dates of transactions may not exceed thirty (30) days retroactive from the next billing date.
3. For group accounts with student dependent coverage: A full-time dependent student is a person who meets all of these conditions: He/she is at least 19 years of age, unmarried, receives at least half of his/her support from the employee or member, and is enrolled full-time in an accredited educational institution. The institution must grant a degree or diploma.
To enroll the dependent as a full-time student, attach a completed Student Verification Parent Affidavit Form. See your group plan administrator or go to the EmblemHealth Web site at www.emblemhealth.com for a Student Verification Parent Affidavit Form.
4. Failure to complete any part of this form (e.g., group number, reason for submission, certificate number, signature, etc.) will require EmblemHealth to return this transaction form to the employer group plan administrator and may delay the requested effective date of coverage.



TRANSACTION FORM FOR GROUP ACCOUNTS
 MEMBERSHIP/P.O. BOX 2820 • NEW YORK, NY 10116-2820
 (Please read important information on back before completing this form)
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PLEASE PRINT CLEARLY

INTERNAL USE ONLY
 CONTROL NUMBER

I. SUBSCRIBER INFORMATION										
LAST NAME		FIRST NAME			M.I.	TELEPHONE NUMBERS HOME WORK		EMAIL ADDRESS		
HOME ADDRESS		APT. NO.	SOCIAL SECURITY NUMBER (REQUIRED)			GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female		MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other _____		
CITY			STATE	ZIP CODE		PRIMARY LANGUAGE SPOKEN				

II. ENROLLMENT INFORMATION											
LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH MO/DAY/YR	SOCIAL SECURITY NUMBER (REQUIRED)	GENDER	RELATIONSHIP	MAILING ADDRESS (If different from above)	Required for EH CompreHealth		ADD ✓	DELETE ✓
								PRIMARY CARE PHYSICIAN ID Number	OB/GYN SELECTION ID Number		
SUBSCRIBER						SELF					
SPOUSE											
DEPENDENT											
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III. OTHER CARRIER INFORMATION Do you or any of your dependents have other health care coverage? <input type="checkbox"/> Yes Please complete this section <input type="checkbox"/> No GO TO SECTION IV										
NAME OF SUBSCRIBER'S OTHER INSURANCE CARRIER		INSURANCE CO. PHONE #	TYPE OF CONTRACT <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Family		NAME OF POLICYHOLDER: LAST NAME FIRST NAME M.I.			POLICY ID. NUMBER	EFFECTIVE DATE	
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IV. DID YOU HAVE PRIOR HEALTH COVERAGE? <input type="checkbox"/> YES Please provide a 12-month history of all coverage in this section (Use additional pages if you need more space) <input type="checkbox"/> NO GO TO SECTION V							
NAME AND ADDRESS OF INSURER		TELEPHONE NUMBER OF INSURER	NAME OF POLICYHOLDER		POLICY I.D. NUMBER	EFFECTIVE DATE OF CURRENT OR PRIOR POLICY	TERMINATION DATE OF CURRENT OR PRIOR POLICY

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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 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.	
If I am required to contribute to the premium for my coverage, I hereby authorize my employer to deduct such contributions in advance from wages due me and to remit same to EmblemHealth.	
Your signature is required to process this form. Your signature attests that you have read the above, and the reverse side of this form.	
_____	_____
Applicant must sign here	Date

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Check one: <input type="checkbox"/> New Enrollment <input type="checkbox"/> Reinstatement <input type="checkbox"/> Termination <input type="checkbox"/> Change to Individual Policy STATUS CHANGE: <input type="checkbox"/> Add Dependent <input type="checkbox"/> Remove Dependent <input type="checkbox"/> Address Change <input type="checkbox"/> Name Change Reason for Change: _____ TRANSFER: <input type="checkbox"/> To Another Carrier <input type="checkbox"/> EmblemHealth Group # Change: From _____ To _____ Is applicant currently working at least 20 hours per week? <input type="checkbox"/> Yes <input type="checkbox"/> No			NUMBER OF ACTIVE EMPLOYEES IN YOUR GROUP _____		
NAME OF GROUP		GROUP NUMBER: MED/HOSPITAL: DENTAL		SELECT ONE: <input type="checkbox"/> EmblemHealth CompreHealth (small groups only) <input type="checkbox"/> EmblemHealth PPO <input type="checkbox"/> EmblemHealth ConsumerDirect PPO <input type="checkbox"/> EmblemHealth CompreHealth EPO (large groups only) <input type="checkbox"/> EmblemHealth InBalance EPO <input type="checkbox"/> EmblemHealth ConsumerDirect EPO <input type="checkbox"/> EmblemHealth EPO <input type="checkbox"/> EmblemHealth InBalance PPO	
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		Documentation Required	Sole Proprietorship or One Subscriber Group	Association of Two or More Employees	Small Group - Less Than 50 Employees
<input type="checkbox"/> Add Subscriber	New Hire or Change in Plan	For eligible employees who work more than 20 hours weekly, provide a recent copy of NYS45 showing this subscriber as an employee or copy of payroll documentation reflecting the date, employee's name and Social Security # or the employee's current year W4 form.	Not Eligible		
<input type="checkbox"/> Add Spouse	Marriage Court Order	<input type="checkbox"/> Marriage Certificate <input type="checkbox"/> Court Order			
<input type="checkbox"/> Add Dependent	Birth Adoption Court Order	<input type="checkbox"/> Birth Certificate or <input type="checkbox"/> Formal Adoption Papers or <input type="checkbox"/> Court Approved Guardianship Papers or <input type="checkbox"/> Court Order			
<input type="checkbox"/> Add Spouse <input type="checkbox"/> Add Dependent	Loss of Coverage	Certificate of Creditable Coverage			

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PROCESSED BY	RECEIVED DATE	PROCESSED DATE

IMPORTANT INFORMATION

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To enroll the dependent as a full-time student, attach a completed Student Verification Parent Affidavit Form. See your group plan administrator or go to the EmblemHealth Web site at www.emblemhealth.com for a Student Verification Parent Affidavit Form.
4. Failure to complete any part of this form (e.g., group number, reason for submission, certificate number, signature, etc.) will require EmblemHealth to return this transaction form to the employer group plan administrator and may delay the requested effective date of coverage.

SECTION I: GROUP INFORMATION

Company Name _____ Date _____

Address _____

City _____ State _____ ZIP _____ County _____

Telephone No. (_____) _____ Fax No. (_____) _____

Company Officer's Name _____ E-Mail Address _____

Title _____

Group Contact _____ Title _____ Telephone No. (_____) _____

E-Mail Address _____

Address Same as above _____

Additional Office Locations _____

Taxpayer ID Number _____

SECTION II: BILLING

Premium invoices should be sent to: _____

Telephone No. (_____) _____ E-Mail Address _____

Address _____

City _____ State _____ ZIP _____ County _____

Contact Person *(if different than above)* _____

Telephone No. (_____) _____ E-Mail Address _____

SECTION III: GROUP ADMINISTRATION

1. Please check all applicable class(es) for the EmblemHealth coverage for which you are applying (note that classes must be based upon conditions pertaining to employment):

- Management Non-Management Union Part-Time Other

If you checked "Other" above, please identify the other class(es): _____

NOTE: Employees must work at least 20 hours per week for applicant in order to be eligible for EmblemHealth coverage. Retirees are not eligible for coverage under EmblemHealth small group programs.

At EmblemHealth's request, employer's quarterly report of wages paid to each employees (NYS-45) must be supplied to EmblemHealth within 15 days after it is filed with New York State.

2. If your Group is an association, chamber of commerce or fund comprised of one or more employees or labor unions, please identify the total number of member groups by the following group size(s):

_____ Total number of member groups with 50 or fewer eligible employees.

_____ Total number of member groups with 51 or more eligible employees.

3. Please specify the current number of COBRA participants: _____

4. Indicate the number of enrollees eligible for EmblemHealth by coverage type:

_____ Individual _____ Employee/Spouse _____ Employee/Child(ren) _____ Family

5. Pre-Existing Condition Limitation:

There will be a waiting period of up to 12 months for benefits for any condition for which medical advice, diagnosis, care or treatment was recommended or received during the six-month period ending on a member's enrollment date. This waiting period will be reduced to the extent that a member is entitled by law to a credit for prior continuous creditable coverage. The Certificate of Insurance or Certificate of Coverage will contain more information about the pre-existing condition waiting period and the types of coverage that qualify as prior continuous creditable coverage. The CompreHealth program applies a 12-month pre-existing condition limitation. Other EmblemHealth small group products apply an 11-month pre-existing condition limitation.

6. What is the nature of your business or organization? _____

Which of the following describes your company or organization?

Employer/Employee Group Business Association Fraternal/Religious Organization

Sole Proprietor Partnership Non-Profit Organization

Other Group. Please describe _____

Which of the following describes your type of Association?

Trade Association Labor Union or Employer Trust

Professional Association Chamber of Commerce

Credit or Bank Association Special Association (Approved by Department of Insurance)

7. Is your company or organization a subsidiary, division or an affiliate of another company?

Yes No

SECTION IV: OTHER COVERAGE

OTHER GROUP HEALTH OR HMO COVERAGE

Please complete the information below for your other group health coverage which is still in force or which was terminated within the past 12 months.

Name and Address of Insurer	Type of Coverage	Effective Date of Policy	Termination Date of Policy

Was your group health coverage terminated for non-payment of premiums in the last 12 months?

Yes No

SECTION V: PRODUCT SELECTION

EMBLEMHEALTH PRODUCTS

Desired Effective Date: _____

EPO

- Are all eligible employees covered under this program? Yes No
- If no, are at least 50% of the eligible employees selecting this program or another group health program? Yes No
- Will this program replace another group health coverage program? Yes No

PPO

- Are all eligible employees selecting this program? Yes No
- If no, are at least 50% of the eligible employees selecting this program or another EmblemHealth program? Yes No
- Will this program replace another group health coverage program? Yes No

InBalance EPO

- Are all eligible employees selecting this program? Yes No
- If no, are at least 50% of the eligible employees selecting this program or another group health program? Yes No
- Will this program replace another group health coverage program? Yes No

InBalance PPO

- Are all eligible employees selecting this program? Yes No
- If no, are at least 50% of the eligible employees selecting this program or another EmblemHealth program? Yes No
- Will this program replace another group health coverage program? Yes No

- ConsumerDirect EPO**
- Are all eligible employees selecting this program? Yes No
 - If no, are at least 50% of the eligible employees selecting this program or another group health program? Yes No
 - Will this program replace another group health coverage program? Yes No

- ConsumerDirect PPO**
- Are all eligible employees selecting this program? Yes No
 - If no, are at least 50% of the eligible employees selecting this program or another EmblemHealth program? Yes No
 - Will this program replace another group health coverage program? Yes No

- CompreHealth**
- Are all eligible employees selecting this program? Yes No
 - Will this program replace another group health coverage program? Yes No

EmblemHealth Dental Voluntary Contributory

SECTION VI: ENROLLMENT POLICIES CLASS: _____

EMPLOYER CONTRIBUTIONS

Please specify the percent or amount that your group will contribute towards EmblemHealth Program premiums for your employees and their dependents.

Employee: _____ % or \$ _____ Family: _____ % or \$ _____

Other: _____

NEW HIRE ELIGIBILITY POLICY

Please specify the date on which a new employee will be eligible for coverage under the EmblemHealth program.

Date of hire First of the month following date of hire

PLUS:

30 Days 60 Days 90 Days Other: _____

Waived for rehire? Yes No If rehired within _____ days of rehire.

If more than one class of employees will be covered, please complete **Section (VI-A)** on next page.

SECTION VI-A: ENROLLMENT POLICIES CLASS: _____

EMPLOYER CONTRIBUTIONS

Please specify the percent or amount that your group will contribute towards EmblemHealth Program premiums for your employees and their dependents.

- Employee:** _____ % or \$ _____ **Family:** _____ % or \$ _____
- Other: _____

NEW HIRE ELIGIBILITY POLICY

Please specify the date on which a new employee will be eligible for coverage under the EmblemHealth Program.

- Date of hire First of the month following date of hire

PLUS:

- 30 Days 60 Days 90 Days Other: _____

Waived for rehire? Yes No If rehired within _____ days of rehire.

For additional classes, please continue on a separate piece of paper.

SECTION VII

For employer groups comprised of one or more employees, please check your current employer status below to ensure proper coordination of benefits for your Medicare Eligible Active Employees (*you must check one of the boxes below*):

- A.** Employed fewer than twenty (20) full time or part time employees for twenty (20) or more calendar weeks for each working day in each of twenty (20) or more calendar weeks in the current calendar year (or the preceding calendar year).
- Employed twenty (20) or more full or part-time employees for twenty (20) or more calendar weeks for each working day in each of twenty (20) or more calendar weeks in the current calendar year (or the preceding calendar year)

NOTE: All employers that are treated as a single employer under Internal Revenue Code Section 52 must be treated as a single employer for purpose of the Medicare secondary payer rules. According to Internal Revenue Code Section 52, all employees of all corporations that are members of the same controlled group of corporations must be treated as employed by a single employer. This means that if a parent company owns at least fifty percent (50%) of a subsidiary, then the number of employees of the parent and the subsidiary must be combined for purposes of determining the 20-employee threshold. Similarly, brother-sister corporations may be combined in some cases if the parent corporation owns at least fifty percent (50%) of the brother-sister corporations.

- B.** Please check here if your group is a large group health plan. A large group health plan is a plan of, or contributed to by, an employer or employee organization to provide health benefits that cover the employees of at least one (1) employer that normally employed at least one hundred (100) employees on a typical business day during the preceding calendar year.

SECTION VIII

The group agrees to do the following:

- Make payroll deductions, if employee contributions are required, and remit to HIP Health Plan of New York, or Group Health Incorporated the premiums payable in accordance with the terms of the Contract. Failure to pay on time could result in the termination of the group's coverage.
- Promptly notify HIP Health Plan of New York, and/or Group Health Incorporated, of the termination or addition of any member(s) covered or to be covered.
- Promptly provide HIP Health Plan of New York, or Group Health Incorporated with any information necessary to properly administer the coverage.
- Ensure compliance with ERISA/TEFRA/DEFRA/COBRA/OBRA and any other legislation pertaining to your group's coverage, as applicable.

It is understood that:

- If an acceptable employee enrollment form is received prior to the eligibility date, coverage will begin on the date of eligibility.
- If an acceptable employee enrollment form is received subsequent to the eligibility date, coverage will begin on the date of receipt.
- All group applications are subject to approval by HIP Health Plan of New York and/or Group Health Incorporated.

I, the undersigned, understand and agree that this application is for health insurance coverage offered by HIP Health Plan of New York, and/or Group Health Incorporated, and will form a part of any Contract issued in reliance upon it. Acceptance of the group for coverage and the final rates are based upon the above information and the eligibility of the actual enrollees. Any material misrepresentation within this group application or the enrollee transaction and application form, whether intentional or unintentional, may cause termination of this coverage subject to the terms of the Contract. I understand and agree that it is my responsibility to offer coverage to all eligible employees and their dependents, and I will provide an enrollment form or a waiver of coverage form signed by each eligible employee within thirty (30) days of his/her eligibility date.

I also understand that any existing coverage presently being provided to employees should not be canceled until written approval of this application has been received. I am submitting a one (1) month premium deposit to be held without obligation until this application is approved. This premium deposit will be applied to the applicable premium billing/payment frequency I selected under this Contract. The premium deposit submitted with this application will be refunded if coverage does not become effective.

Subject to applicable State and Federal laws pertaining to pre-existing conditions and creditable coverage, benefits for pre-existing conditions may not be payable for up to twelve months from the effective date of this Contract.

All statements in this application for coverage under a Contract for insurance shall be deemed representations and not warranties, and no such statements shall be used to deny a claim under the Contract, unless the statements are made in the application or in addenda attached to the Contract.

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 material fact associated with such application commits a fraudulent insurance act. Such act is a crime, and will be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signed at: _____

On the _____ Day of _____, 20_____

By: _____ Title: _____

By: _____ Title: _____

Please return all items listed in cover letter to:

TO: The Peconic Bay Business Assoc.
860 E. Main St.
Riverhead, NY 11901

COVERAGE IS NOT EFFECTIVE UNTIL WE NOTIFY YOU IN WRITING

SECTION IX

To be completed by EmblemHealth General Agent or Selling Agent:

Company Name _____ Date _____

Address _____

City _____ State _____ ZIP _____ County _____

Telephone No. () _____ Fax No. () _____

Group Contact _____ E-Mail Address _____

Desired Effective Date _____

Effective date changed since original application? Yes No

Master Agency _____ MA No. _____ Override _____

EmblemHealth Group No. _____ EmblemHealth Marketing Rep _____

LETTER OF CERTIFICATION

This form must be completed by a licensed attorney or a Certified Public Accountant (CPA) who is not related to either a) a principal or senior executive of the group or b) any employee of the group.

I am submitting this letter of certification to Group Health Incorporated (GHI) on behalf of the group shown below. I understand that GHI will use the information provided in this certification, as well as in any supporting documentation, as part of the group's application for insurance to determine eligibility and/or to make underwriting decisions.

I am a duly licensed (check one):

- Attorney
- Certified Public Account (CPA)

Section I. Please provide your name and your firm's name, address, telephone number, and state of licensure.

Name: _____
Firm Name: _____
Firm Address: _____
Telephone Number: _____
State of Licensure: _____

Section II. Please provide the following information on the group.

This letter of certification is provided on behalf of the following business entity:

Group's Name: _____
Group's Address: _____
Group's Telephone Number: _____ Group's TIN: _____

This group's principal place of business is New York. This business is a (check one box only):

- Sole Proprietorship, and the proprietor works a minimum of 20 hours per week
 - Partnership
 - Corporation
 - Limited Liability Company (LLC)
 - Trust (attach supporting documentation)
 - Other type of business entity (explain and attach copies of supporting documentation)
- _____

Section III. Check one or both boxes below:

- The following new employee _____ is a bona fide employee who began working for this company on _____, works full-time (20 hours or more per week), and will be shown on payroll tax documents, which can be reviewed by GHI on or after _____.
- This group is a new business, which started on _____. The firm's tax year ends on _____. The group will be filing tax documents on or about _____, which can be reviewed at a future date.

I hereby certify that the information stated above is true based upon my review of the books, records, or other written documentation provided to me by the group. I further certify that

the documentation I have attached to this letter in support of this certification are true and are accurate copies of the group's records. This certification forms part of the group's application for insurance. New York State insurance law provides that any person who knowingly and with the 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 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.

Signature of person completing form: _____

Print Name and Title: _____

Date: _____

First HSA
 2561 Bernville Rd.
 Reading, PA 19605
 (Ph) 610-678-6000 or 888-769-8696
 (Fax) 610-678-6818
 Website: www.1hsa.com



Agent Name: _____

Agency: _____

Agents must sign up at www.1hsa.com

Health Savings Account Application

Applicant Information										
*First Name		Middle Initial		*Last Name			*Soc. Sec. #		*Date of Birth (mm/dd/yyyy)	
*Address (if P.O. Box – also provide street address)						*City		*State		*Zip:
*Driver's License # or State ID#				*State:		*Issue Date:		*Expiration Date:		
*Home Phone:		Business Phone:			E-mail Address:				Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Company Name			Phone Number		Contact Person			Email Address		
Company Address				City			State		Zip Code	
Designation of Beneficiaries: I hereby certify that if I die before distribution has been completed, the value of my Health Savings Account shall be distributed to the Beneficiaries named below. Use a separate paper for additional beneficiaries.										
Primary Name				Soc. Sec #			Relationship		Date of Birth	
Percent	Address			City			State		Zip	
Contingent Name				Soc. Sec #			Relationship		Date of Birth	
Percent	Address			City			State		Zip	
Authorized Signor (optional) – I hereby designate the following individual as additional authorized signor on my Health Savings Account										
Primary Name				Soc. Sec #			Relationship		Date of Birth	
<input type="checkbox"/> Order Additional Check Card—Your account will be debited \$5 for the additional card.										
Fees and Deposits										
Insurance Company			Plan Type <input type="checkbox"/> Individual <input type="checkbox"/> Family			Annual Deductible		Effective Date		
*Fee Type	<input type="checkbox"/> \$3 Monthly Admin. Fee-Automatic Debit (no charge for an e-statement) or <input type="checkbox"/> \$5 Monthly Admin. Fee-Automatic Debit (Additional \$2 for paper statement) or					<input type="checkbox"/> \$36 Annual Admin Fee Payment or <input type="checkbox"/> \$60 Annual Admin Fee Payment		<input type="checkbox"/> Check here to receive initial order of 20 free checks		
*To sign up for e-statements, enter your email address and finalize setup with instructions provided in your welcome kit.										*Email Address
Please remit with application: Make one check payable to "First HSA" . This check should include any current year contributions, and also the \$15.00 one-time setup fee. If set up fee not submitted, it will be taken from initial deposit. When choosing the Annual Payment Option , the first year is pro-rated for only those months remaining in the current year. Total the number of months remaining in the year and multiply by either \$3.00 or \$5.00 depending on the plan type selected. Include this amount with your remittance. Any extra funds submitted will be deposited into account. A minimum opening deposit of \$50.00 is required when contributing by check. No minimum opening balance is required if contributing through direct deposit or payroll deduction.										
Direct Deposits – no dates allowed after the 28 th of the month - Attach a voided check or enter personal account information:										
Routing # _____		Account # _____		Name on Account _____			Amount \$ _____			
<input type="checkbox"/> One Time Date _____	<input type="checkbox"/> Bi Weekly – select 2 days of the month day _____ & day _____ (same amt for both days)			<input type="checkbox"/> Monthly – select the day of the month day _____			<input type="checkbox"/> Annually Date _____			
Disclaimer and Signature										
*TIN Certification: Under penalties of perjury, I certify that the social security number shown on this form is my correct taxpayer identification number <input type="checkbox"/> I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and (3) I am a US Citizen or resident alien. <input type="checkbox"/> I am subject to backup withholding because I have been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest and dividends and I am a US Citizen or resident alien The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.										
Health Savings Account Adoption Agreement: This agreement when signed by me and accepted by First HSA acting as an agent for VIST Bank, as Custodian, incorporates the VIST Bank HSA Custodial Agreement (the "HSA Agreement"). By signing this Agreement, I acknowledge: 1) That there are fees for the First HSA Account. 2) That I must be covered by a HSA-qualify "high deductible" health plan to be eligible to make HSA contributions (other than roll-over contributions) or have HSA contributions made by my employer. 3) That my HSA has been established for the purpose of paying qualified medical expenses, and if distributions are not used for this purpose, I may be subject to ordinary income and penalty taxes, which I must report to the IRS. 4) That no loans may be taken from my HSA and no portion of my HSA may be used as security or collateral for a loan. 5) That I am responsible for reporting my HSA and that First HSA has no duty to determine the investment, tax or other consequences resulting from my actions involving my HSA. 6) That First HSA is not an insurance company who offers the high deductible insurance plans. 7) That I will receive a copy of the HSA Custodial Agreement and Disclosures, Electronic Fund Transfer Agreement and Disclosure, Check and Funds Availability Disclosure (if you request checks), Account Agreement, Truth in Savings Disclosure and Your Financial Privacy at VIST Financial Corp. (Member FDIC) – All account holders will receive a VISA check card upon account opening.										
*Signature								Date		

*required fields



First HSA
HSA Transfer Processing
2561 Bernville Road
Reading, PA 19605

1. General Information

Name..... SSN.....
Street Address City..... State Zip.....
Date of Birth..... Daytime Phone Home Phone

2. Transfer Request

I authorize and direct you, the present Custodian/Trustee, to send as a transfer of assets indicated in Section 3 below to the Custodian/Trustee named on the upper right corner of this form.

- HSA to HSA
IRA (Traditional or Roth - NO Simple or SEP) *\$
*One Time Restriction - amount transferred will be added to your normal contribution amount for this year

HRA/FSA to HSA - amount to be transferred ** \$
**The amounts rolled over to HSA's from FSAs or HRAs are over and above the amounts allowed as annual contributions. The provision is limited to one distribution with respect to each health FSA or HRA of the individual.

Present Custodian/Trustee's Name..... Acct # Ph #
Street Address..... City State Zip

3. Payment Information

A. New Account number

B. Payment Schedule. I authorize and direct you to send my assets as follows:

- (1) Immediately liquidate all assets and send the cash proceeds.
(2) Send cash proceeds of all investments at maturity.
(3) Send the assets at maturity for the investments listed below.
(4) Immediately send all assets "in kind."
(5) Other.....
Investments Maturity Date

C. Payment Method. I authorize and direct you to send my assets to the Custodian/Trustee named above as follows:

- (1) By check. Please make check payable to: First HSA
FBO:
(2) Other

4. Signatures

I certify that I have or will establish an account with the Custodian/Trustee named above. I agree to the terms of this form. I understand that I am responsible for determining my eligibility for all transfers or direct rollovers and I agree to indemnify and to hold the Custodian/Trustee harmless against any and all situations arising from an ineligible transfer or direct rollover. I acknowledge that the Custodian/Trustee cannot provide legal advice and I agree to consult with my own tax professional for advice.

The Custodian/Trustee agrees to accept these funds as a transfer or direct rollover.

Signature of HSA Owner Date

Signature of Custodian/Trustee Date

Name of Representative

Representative Phone Number

IMPORTANT INFORMATION ABOUT YOUR PRIVACY RIGHTS

NOTICE OF PRIVACY PRACTICES

Effective May 1, 2010

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

EmblemHealth, Inc. is the parent organization of the following companies that provide health benefit plans: Group Health Incorporated (GHI), HIP Health Plan of New York (HIP), HIP Insurance Company of New York, Inc. (HIPIC) and GHI HMO Select Inc. (d/b/a GHI HMO). All of these entities receive administrative and other services from EmblemHealth Services Company LLC which is also an EmblemHealth, Inc. company.

This notice describes the privacy practices of EmblemHealth companies, including GHI, GHI HMO, HIP and HIPIC (**collectively "the Plan"**).

We respect the confidentiality of your health information. We are required by federal and state laws to maintain the privacy of your health information and to send you this notice.

This notice explains how we use information about you and when we can share that information with others. It also informs you about your rights with respect to your health information and how you can exercise these rights.

We use security safeguards and techniques designed to protect your health information that we collect, use or disclose orally, in writing and electronically. We train our employees about our privacy policies and practices, and we limit access to your information to only those employees who need it in order to perform their business responsibilities. We do not sell information about our customers or former customers.

How We Use or Share Information

We may use or share information about you for purposes of payment, treatment and health care operations, including with our business associates. For example:

- **Payment:** We may use your information to process and pay claims submitted to us by you or your doctors, hospitals and other health care providers in connection with medical services provided to you.
- **Treatment:** We may share your information with your doctors, hospitals, or other providers to help them provide medical care to you. For example, if you are in the hospital, we may give the hospital access to any medical records sent to us by your doctor.

- **Health Care Operations:** We may use and share your information in connection with our health care operations. These include, but are not limited to:

- Sending you a reminder about appointment with your doctor or recommended health screenings.
 - Giving you information about alternative medical treatments and programs or about health-related products and services that you may be interested in. For example, we might send you information about stopping smoking or weight loss programs.
 - Performing coordination of care and case management.
 - Conducting activities to improve the health or reduce the health care costs of our members. For example, we may use or share your information with others to help manage your health care. We may also talk to your doctor to suggest a disease management or wellness program that could help improve your health.
 - Managing our business and performing general administrative activities, such as customer service and resolving internal grievances and appeals.
 - Conducting medical reviews, audits, fraud and abuse detection, and compliance and legal services.
 - Conducting business planning and development, rating our risk and determining our premium rates. However, we will not use your genetic information for underwriting purposes.
 - Reviewing the competence, qualifications, or performance of our network providers, and conducting training programs, accreditation, certification, licensing, credentialing and other quality assessment and improvement activities.
- **Business Associates:** We may share your information with others who help us conduct our business operations, provided they agree to keep your information confidential.



EmblemHealth[®]

GHI and HIP are EmblemHealth companies

Group Health Incorporated (GHI), HIP Health Plan of New York (HIP), HIP Insurance Company of New York and EmblemHealth Services Company, LLC are EmblemHealth companies. EmblemHealth Services Company, LLC provides administrative services to the EmblemHealth companies.



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Other Ways We Use or Share Information

We may also use and share your information for the following other purposes:

- We may use or share your information with the employer or other health-plan sponsor through which you receive your health benefits. We will not share individually identifiable health information with your benefits plan unless they promise to keep it protected and use it only for purposes relating to the administration of your health benefits.
- We may share your information with a health plan, provider, or health care clearinghouse that participates with us in an organized health care arrangement. We will only share your information for health care operations activities associated with that arrangement.
- We may share your information with another health plan that provides or has provided coverage to you for payment purposes. We may also share your information with another health plan, provider or health care clearinghouse that has or had a relationship with you for the purpose of quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, or detecting or preventing health care fraud and abuse.
- We may share your information with a family member, friend, or other person who is assisting you with your health care or payment for your health care. We may also share information about your location, general condition, or death to notify or help notify (including identifying and locating) a person involved with your care or to help with disaster-relief efforts. Before we share this information, we will provide you with an opportunity to object. If you are not present, or in the event of your incapacity or an emergency, we will share your information based on our professional judgment of whether the disclosure would be in your best interest.

State and Federal Laws Allow Us to Share Information

There are also state and federal laws that allow or may require us to release your health information to others. We may share your information for the following reasons:

- We may report or share information with state and federal agencies that regulate the health care or health insurance system such as the U.S. Department of Health and Human Services, the New York State Insurance Department and the New York State Department of Health.
- We may share information for public health and safety purposes. For example, we may report information to the extent necessary to avert an imminent threat to your safety or the health or safety of others. We may report information to the appropriate authorities if we have reasonable belief that you might be a victim of abuse, neglect, domestic violence or other crimes.

- We may provide information to a court or administrative agency (for example, in response to a court order, search warrant, or subpoena).
- We may report information for certain law enforcement purposes. For example, we may give information to a law enforcement official for purposes of identifying or locating a suspect, fugitive, material witness or missing person.
- We may share information with a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also share information with funeral directors as necessary to carry out their duties.
- We may use or share information for procurement, banking or transplantation of organs, eyes or tissue.
- We may share information relative to specialized government functions, such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others, and to correctional institutions and in other law enforcement custodial situations.
- We may report information on job-related injuries because of requirements of your state worker compensation laws.
- Under certain circumstances, we may share information for purposes of research.

Sensitive Information

Certain types of especially sensitive health information, such as HIV-related, mental health and substance abuse treatment records, are subject to heightened protection under the law. If any state or federal law or regulation governing this type of sensitive information restricts us from using or sharing your information in any manner otherwise permitted under this Notice, we will follow the more restrictive law or regulation.

Your Authorization

If one of the preceding reasons does not apply, we must get your written authorization to use or disclose your health information. If you give us written authorization and change your mind, you may revoke your written authorization at any time, except to the extent we have already acted in reliance on your authorization. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not re-disclose the information.

We have an authorization form that describes the purpose for which the information is to be used, the time period during which the authorization form will be in effect, and your right to revoke authorization at any time. The authorization form must be completed and signed by you or your duly authorized representative and returned to us before we will disclose any of your protected health information. You can obtain a copy of this form by calling the Customer Service phone number on the back of your ID card.

Your Rights

The following are your rights with respect to the privacy of your health information. If you would like to exercise any of the following rights, please contact us by calling the telephone number shown on the back of your ID card.

Restricting Your Information

- **You have the right to ask us to restrict** how we use or disclose your information for treatment, payment or health care operations. You also have the right to ask us to restrict information that we have been asked to give to family members or to others who are involved in your health care or payment for your health care. Please note that while we will try to honor your request, we are not required to agree to these restrictions.

Confidential Communications for Your Information

- **You have the right to ask to receive confidential communications** of information if you believe that you would be endangered if we send your information to your current mailing address (for example, in situations involving domestic disputes or violence). If you are a minor and have received health care services based on your own consent or in certain other circumstances, you also may have the right to request to receive confidential communications in certain circumstances, if permitted by state law. You can ask us to send the information to an alternative address or by alternative means, such as by fax. We may require that your request be in writing and you specify the alternative means or location, as well as the reason for your request. We will accommodate reasonable requests. Please be aware that the explanation of benefits statement(s) that the Plan issues to the contract holder or certificate holder may contain sufficient information to reveal that you obtained health care for which the Plan paid, even though you have asked that we communicate with you about your health care in confidence.

Inspecting Your Information

- **You have the right to inspect and obtain a copy** of information that we maintain about you in your designated record set. A "designated record set" is the group of records used by or for us to make benefit decisions about you. This can include enrollment, payment, claims and case or medical management records. We may require that your request be in writing. We may charge a fee for copying information or preparing a summary or explanation of the information and in certain situations, we may deny your request to inspect or obtain a copy of your information.

Amending Your Information

- **You have the right to ask us to amend** information we maintain about you in your designated record set. We may require that your request be in writing and that you provide a reason for your request. We may deny your request for an amendment if we

did not create the information that you want amended and the originator remains available or for certain other reasons. If we deny your request, you may file a written statement of disagreement.

Accounting of Disclosures

- **You have the right to receive an accounting** of certain disclosures of your information made by us for purposes other than treatment, payment or health care operations during the six years prior to your request. We may require that your request be in writing. If you request such an accounting more than once in a 12-month period, we may charge a reasonable fee.

Please note that we are not required to provide an accounting of the following:

- Any information collected prior to April 14, 2003.
- Information disclosed or used for treatment, payment and health care operations purposes.
- Information disclosed to you or following your authorization.
- Information that is incidental to a use or disclosure otherwise permitted.
- Information disclosed to persons involved in your care or other notification purposes.
- Information disclosed for national security or intelligence purposes.
- Information disclosed to correctional institutions or law enforcement officials.
- Information that was disclosed or used as part of a limited data set for research, public health or health care operations purposes.

Collecting, Sharing and Safeguarding Your Financial Information

In addition to health information, the plan may collect and share other types of information about you. We may collect and share the following types of personal information:

- Name, address, telephone number and/or email address;
- Names, addresses, telephone numbers and/or email addresses of your spouse and dependents;
- Your social security number, age, gender and marital status;
- Social security numbers, age, gender and marital status of your spouse and dependents;
- Any information that we receive about you and your family from your applications or when we administer your policy, claim or account;
- If you purchase a group policy for your business, information to verify the existence, nature, location and size of your business.
- We also collect income and asset information from Medicaid, Child Health Plus, Family Health Plus and Healthy New York subscribers. We may also collect this information from Medicare subscribers to determine eligibility for government subsidized programs.

We may share this information with our affiliates and with business associates that perform services on our behalf. For example, we may share such information with vendors that print and mail member materials to you on our behalf and with entities that perform claims processing, medical review and other services on our behalf. These business associates must maintain the confidentiality of the information. We may also share such information when necessary to process transactions at your request and for certain other purposes permitted by law.

To the extent that such information may be or become part of your medical records, claims history or other health information, the information will be treated like health information as described in this notice.

As with health information, we use security safeguards and techniques designed to protect your personal information that we collect, use or disclose in writing, orally and electronically. We train our employees about our privacy policies and practices, and we limit access to your information to only those employees who need it in order to perform their business responsibilities. We do not sell information about our customers or former customers.

Exercising Your Rights, Complaints and Questions

- **You have the right to receive a paper copy of this notice upon request at any time.** You can also view a copy of this notice on the Web site. See information at the end of this page. We must abide by the terms of this notice.
- **If you have any questions** or would like further information about this notice or about how we use or share information, you may write to the Corporate Compliance Department or call Customer Service. Please see the contact information on this page.
- **If you believe that we may have violated your privacy rights, you may file a complaint.**

We will take no action against you for filing a complaint.

Call Customer Service at the telephone number and during the hours of operation listed on this page. You can also file a complaint by mail to the Corporate Compliance Department at the mailing address on this page. You may also notify the Secretary of the U.S. Department of Health and Human Services.

If we become aware that we or one of our business associates has experienced a breach of your personal information, as defined by federal and state laws, we will take action in accordance with applicable laws and regulations. This may include notifying you and certain governmental, regulatory and media agencies about the breach.

Contact Information

Please check the back of your ID card to call us or use the following contact information for your plan. Read carefully to select the correct Customer Service number or mailing address.

Write to:

For all HIP, HIPIC, GHI members (except GHI HMO and GHI FHP) and EmblemHealth program members:
Corporate Compliance Dept.
P.O. Box 2878
New York, NY 10116-2878

For all GHI HMO and GHI FHP members:
Corporate Compliance Dept.
P.O. Box 4443
Kingston, NY 12402-4443

Call:

For all GHI members: **1-800-624-2414, TTY-1-866-248-0640,**
M-F, 8 am-5 pm

For all GHI, Medicare Part D (NYC employee retirees) members:
1-800-624-2414, TTY-1-866-248-0640, M-F, 8 am-8 pm

For GHI Medicare Advantage and Medicaid Advantage members:
1-866-557-7300, TTY-1-866-248-0640, M-F, 8 am-8 pm

For all GHI Medicare Part D (non-NYC employee retirees) members:
1-877-444-7241, TTY-1-888-447-4833, M-F, 8 am-8 pm

For all GHI HMO and GHI FHP PPO members: **1-877-244-4466,**
TTY-1-877-208-7920, M-F, 8 am-6 pm

For all HIP and HIPIC members: **1-800-447-8255,**
TTY-1-888-447-4833, M-F, 8 am-6 pm

For all HIP Medicare Advantage, Medicare Part D and Medicaid Advantage members: **1-800-447-8255, TTY-1-888-447-4833,**
M-F, 8 am-8 pm

For all EmblemHealth program members: **1-877-842-3625,**
TTY-1-866-248-0640, M-F, 8 am-5 pm

Personal Information After You Are No Longer Enrolled

Even after you are no longer enrolled in any plan, we may maintain your personal information as required by law or as necessary to carry out plan administration activities on your behalf. Our policies and procedures that safeguard that information against inappropriate use and disclosure still apply if you are no longer enrolled in the Plan.

Changes to this Notice

We are required to abide by the terms of this Notice of Privacy Practices as currently in effect. We reserve the right to change the terms of the notice and to make the new notice effective for all the protected health information that we maintain. Prior to implementing any material changes to our privacy practices, we will promptly revise and distribute our notice to our customers. In addition, for the convenience of our members, the revised privacy notice will also be posted on our Web sites:

All GHI and GHI HMO members: www.ghi.com

All HIP and HIPIC members: www.hipusa.com

All EmblemHealth program members: www.emblemhealth.com