

SONNY A. HENNING INSURANCE

INSURANCE PROCESSING CENTER - 9671 CASTLE WOODS COVE, INDIANAPOLIS, IN 46280 · FAX 888-766-8288
TOLL FREE 1-888-SONNY-32

Thank you for your interest in GHI EPO for Groups of One. I have attached more detailed plan descriptions for the quoted programs.

Please print the attached file and complete all applications. Paperwork and checks must be returned to:

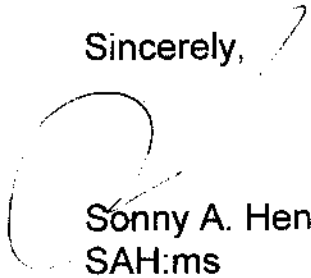
**SONNY A. HENNING
SONNY HENNING INSURANCE
9671 CASTLE WOODS COVE
INDIANAPOLIS, IN 46280**

Please include a check for \$57 payable to IRBA; plus a check for the first month's premium of the plan you select, payable to National Administrators; PLUS a one time processing fee of \$50, payable to Sonny Henning Insurance. You must include a copy of Schedule C to prove self-employment.

All forms must be received by the 15th of the month for a 1st of the following month effective date, or your plan can be effective within 6 business days from receipt of application forms.

If you have any questions, please feel free to call, toll free at your convenience **1-888 SONNY-32 (1-888-766-6932)**.

Sincerely,



Sonny A. Henning
SAH:ms
Attachments

**4
New Plans
Added For
2004**

GHI EPO

**For Groups of One
In Network Benefits Only**

Plan Underwritten by:
Group Health Incorporated (GHI)
141 Ninth Avenue
New York, NY 10001

Available
Through
IRBA

Effective 1/1/2004

1st Quarter 2004

2 Tier

Available in NYC, Bronx, Queens, Kings, Richmond, Nassau, Suffolk, Westchester and Rockland

GHI EPO Plan 1

In Network Benefits Only - GHI's CBP Network
"No Referrals Required"

\$15 Office copayment, Lab & Radiology - office copayment, Hospitalization - covered in full, ER Copay \$50, Unlimited Maximum Benefit, RX Option 3 - \$0 deductible, \$10 mandatory generic/\$25 brand/\$40 non-formulary prescriptions, Voluntary mail order

Single \$ 393.47
Family \$1,003.35

GHI EPO Form P11-EPO-100
Prescription Drug Rider Form P11-SG1-978

GHI EPO Plan 2

In Network Benefits Only - GHI's CBP Network
"No Referrals Required"

\$20 Office copayment, Lab & Radiology - office copayment, Hospitalization - covered in full, ER Copay \$50, Unlimited Maximum Benefit, RX Option 3 - \$0 deductible, \$10 mandatory generic/\$25 brand/\$40 non-formulary prescriptions, Voluntary mail order

Single \$ 384.52
Family \$ 980.51

GHI EPO Form P11-EPO-100
Prescription Drug Rider Form P11-SG1-978

GHI EPO Plan 3

In Network Benefits Only - GHI's CBP Network
"No Referrals Required"

\$30 Office copay, Lab & Radiology - office copay, \$500 hospital copay, \$100 ER Copay, \$250 Amb Surg Copay, Unlimited Maximum Benefit, RX Option 3 - \$0 deductible, \$10 mandatory generic/\$25 brand/\$40 non-formulary prescriptions, Voluntary mail order

Single \$ 354.82 **New**
Family \$ 904.79 **Plan!**

GHI EPO Form P11-EPO-100
Prescription Drug Rider Form P11-SG1-978

GHI EPO Plan 4

In Network Benefits Only - GHI's CBP Network
"No Referrals Required"

\$30 Office copayment, Lab & Radiology - office copayment, \$1,000 hospital copay, \$100 ER Copay, \$750 Amb Surgery copay, Unlimited Maximum Benefit, RX Option 3 - \$0 deductible, \$10 mandatory generic/\$25 brand/\$40 non-formulary prescriptions, Voluntary mail order

Single \$ 336.71 **New**
Family \$ 858.61 **Plan!**

GHI EPO Form P11-EPO-100
Prescription Drug Rider Form P11-SG1-978

GHI EPO Plan 5

In Network Benefits Only - GHI's CBP Network
"No Referrals Required"

\$30 Office copayment, Lab & Radiology - office copay, Hospitalization \$500 copay, ER Copay \$100, Amb Surg \$250 copay, Unlimited Maximum Benefit, RX Option 2 - \$50 retail deductible, 10/25/40, \$1,000 Retail Maximum, 20/50/80 Mail Order Copay, Unlimited mail order maximum

Single \$ 327.12
Family \$ 834.12 **New**
Plan!

GHI EPO Form P11-EPO-100
Prescription Drug Rider Form P11-SG1-984

GHI EPO Plan 6

In Network Benefits Only - GHI's CBP Network
"No Referrals Required"

\$30 Office copayment, Lab & Radiology - office copay, \$1,000 Hospital copay, \$100 ER Copay, \$750 Amb Surgery, Unlimited Maximum Benefit, RX Option 2 - \$50 retail deductible, 10/25/40, \$1,000 Retail Maximum, 20/50/80 Mail Order Copay, Unlimited mail order maximum

Single \$ 309.01
Family \$ 787.94 **New**
Plan!

GHI EPO Form P11-EPO-100
Prescription Drug Rider Form P11-SG1-984



INDEPENDENT & RETAIL BUSINESS ASSOCIATES, INC.
The Association for Independent Businesses

MEMBERSHIP APPLICATION

SECTION I - GENERAL INFORMATION

Name of Business: _____

Address: _____

Phone Number: _____

Owner/Manager: _____

Type of Business: _____

Number of Full-time Employees (at least 20.0 hours/week): 1

Number of Part-time Employees (less than 20.0 hours/week): 0

SECTION II - IRBA MEMBERSHIP FEES

Annual Membership dues per business of \$57.00 made payable to "IRBA."

SECTION III

I hereby apply for membership in the Independent and Retail Business Associates, Inc., "IRBA."

Date

Signature of Owner/Manager

Print Name

The information provided above is true and correct to the best of my knowledge. I understand that coverage and benefits may be effected by failure to provide complete and accurate information.

2003 Jericho Turnpike • New Hyde Park, NY 11040 • (516) 352-7000 • Fax (516) 352-3135
Empire State Building • 350 5th Avenue • Suite 5220 • New York, NY 10118 • (212) 947-2200 • Fax (212) 760-1049
1300 N. Congress Avenue • West Palm Beach, FL 33409 • (800) 228-PLAN • (561) 686-0048 • Fax (561) 686-3404
IRBA Headquarters • 4 Airline Drive • Suite 202 • Albany, NY 12205 • (518) 869-3618 • Fax (518) 869-3648 • Toll Free (800) 288-4722

IRBA

INDEPENDENT & RETAIL BUSINESS ASSOCIATES, INC.

GROUP APPLICATION for GHI EPO

Company Name: _____

Address: _____

Company Phone # _____ Type of Business _____

Contact: _____ Title: _____

Total Number of Employees: _____ / _____

Total Number of EE's Working 20 hours or more per week: _____ / _____

Total number of eligible employees: _____ / _____

Total number of subscribers enrolling: _____ / _____

Single: _____ Employee/Spouse: _____ Employee/Child: _____ Family: _____

Present Insurance Carrier: _____

Dates of Coverage: From: _____ / _____ / _____ to _____ / _____ / _____

Requested Effective Date: _____

GUIDELINES FOR ALL PLANS

1. The employer must be a member in good standing of IRBA
2. All payments are to be made to National Administrators, Inc. (NAI) as administrators of IRBA. All applications that you submit must be accompanied with proof of business tax: Schedule C, NYS-45, Certificate of Business, Etc.)
3. All member groups must be self employed or have employer/employee relationships
4. We cannot accept enrollments if they are not properly completed, and accompanied by premium payment.
5. Enrollments, changes and cancellations must be in the administrators office at least 20 days prior to effective date. See Submission Guidelines for exact date.
6. Your premium must be received before the 1st of the month of coverage to avoid termination of coverage.
7. The rates do not include a \$10 monthly billing fee. Billing fee will appear on first invoice and all subsequent invoices.

GHI EPO

Plan Applied For (check ONE plan)

Plan 1 - \$15 Office visit copay, Hospital covered in full, RX-\$10/25/40 voluntary mail order _____

Plan 2 - \$20 Office visit copay, Hospital covered in full, RX- \$10/25/40 voluntary mail order _____

Plan 3 - \$30 Office visit copay, \$500 Hospital copay, RX-\$10/25/40 voluntary mail order _____

Plan 4 - \$30 Office visit copay, \$1,000 Hospital copay, RX- \$10/25/40 voluntary mail order _____

Plan 5 - \$30 Office visit copay, \$500 Hospital copay, RX-\$50 retail ded, \$10/25/40, \$1,000 Retail Max, \$20/\$50/\$80 mail order copay, unlimited mail order maximum _____

Plan 6 - \$30 Office visit copay, \$1,000 Hospital copay, RX-\$50 retail ded, \$10/25/40, \$1,000 Retail Max, \$20/\$50/\$80 mail order copay, unlimited mail order maximum _____

The information provided above is true and correct to the best of my knowledge. I understand that coverage and benefits may be effected by failure to provide complete and accurate information.

Signature of Owner/Partner _____

Date _____

Sonny Henning
Representative (PLEASE PRINT!)

317-566-1540
Representative's Phone Number



TRANSACTION FORM FOR SMALL GROUPS
MEMBERSHIP / P.O. BOX 2820 • NEW YORK, NY 10116-2820

A. REASON(S) FOR SUBMISSION (Check one or more boxes as applicable)

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|---------------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> New Enrollment | <input type="checkbox"/> Address Change | TRANSFER | CHANGE OF DEPENDENTS |
| <input type="checkbox"/> Reinstatement | <input type="checkbox"/> Name Change | | |
| <input type="checkbox"/> Termination | Former Name _____ | <input type="checkbox"/> To Another Carrier | <input type="checkbox"/> Add Spouse |
| <input type="checkbox"/> Change Contract To: <input type="checkbox"/> Individual <input type="checkbox"/> Husband/Wife <input type="checkbox"/> Parent & Child(ren) | | <input type="checkbox"/> From GHI Group No. _____ | <input type="checkbox"/> Delete Spouse |
| <input type="checkbox"/> Family | <input type="checkbox"/> Medicare Carry-Out | To GHI Group No. _____ | <input type="checkbox"/> Add Child(ren) |
| | | | <input type="checkbox"/> Delete Child(ren) |

B. SUBSCRIBER INFORMATION

| | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|----------|----------------------------------------------------------------------------------|------------------------------------------------------------------|
| LAST NAME | FIRST NAME | MI | SOCIAL SECURITY NO. | EMPLOYMENT DATE |
| HOME ADDRESS | | | APT# | DATE OF BIRTH |
| | | | SEX | <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE |
| CITY | STATE | ZIP CODE | MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED | |
| EMPLOYMENT STATUS: <input type="checkbox"/> EMPLOYED <input type="checkbox"/> NOT EMPLOYED <input type="checkbox"/> RETIRED <input type="checkbox"/> COBRA | | | | |
| Telephone number where you can be reached between 9:00am and 5:00pm Monday through Friday () _____ | | | | |

C. DO YOU HAVE PRIOR HEALTH COVERAGE (Check one box)

| | 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 |
|----------|-----------------------------|-----------------------------|----------------------|--------------------|-------------------------------------------|---------------------------------------------|
| Hospital | | | | | | |
| Medical | | | | | | |

D. DEPENDENT INFORMATION (Indicate different last name if applicable)

| LAST NAME | FIRST NAME | MI | DATE OF BIRTH | RELATIONSHIP | FULL-TIME STUDENT YES OR NO | ADD | DELETE |
|-----------|------------|----|---------------|--------------|-----------------------------|-----|--------|
| | | | | | | | |
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E. OTHER CARRIER INFORMATION

Do you or any of your dependents have other health care coverage? Yes No If "Yes", please complete the following information:

| | | | |
|--------------------------------------------|---------------|----------------|---------------------|
| LAST NAME | FIRST NAME | MI | SOCIAL SECURITY NO. |
| OTHER HEALTH INSURANCE CARRIER INFORMATION | POLICY NUMBER | EFFECTIVE DATE | NAME OF CARRIER |
| CARRIER'S ADDRESS | CITY | STATE | ZIP CODE |

F. SUBSCRIBER AUTHORIZATION **GROUP AUTHORIZATION**

Please read statement on the back of this form before signing this document

| | | | |
|------------------------|------|----------------------|------|
| SUBSCRIBER'S SIGNATURE | DATE | AUTHORIZED SIGNATURE | DATE |
|------------------------|------|----------------------|------|

G. GROUP'S NAME AND ADDRESS **EFFECTIVE DATE OF TRANSACTION** **GHI GROUP NUMBER**

| | | |
|--|----------|----------|
| | MEDICAL | MEDICAL |
| | HOSPITAL | HOSPITAL |
| | DENTAL | DENTAL |