

SONNY A. HENNING INSURANCE

9671 CASTLE WOODS COVE, INDIANAPOLIS, IN 46280 FAX 888-766-8288
TOLL FREE 1-888-SONNY-32 (888-766-6932)

Thank you for your interest in our Health Plans. I have attached a more detailed description for the quoted program.

Please print the attached file and complete all application forms per the instructions. 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 \$57.00, payable to IRBA; plus check for the first month's premium of the plan you select. **In addition, please include a check, payable to Sonny Henning Insurance in the amount of \$50.00 as a one time processing and handling fee.**

All forms must be received by the 15th of the month for a 1st of the month effective date.

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

***BE SURE TO REMEMBER US FOR ALL YOUR LIFE AND
HEALTH INSURANCE NEEDS, INCLUDING LIFE, HEALTH,
DISABILITY, LONG TERM CARE AND OTHER SENIOR
PRODUCTS.***

2004 HIP®

THROUGH
IRBA
HIP HMO Rates

Rates Effective 4/1/04

Rates effective 4/1/04

This is for comparative purposes only, for further details please see plan summary.

These rates have not yet been approved by the NY State Department of Insurance.

HIP PRIME VALUE (20/500/50)			
without RX			
\$20 Office Visit Copay except for primary & preventive to age 19. \$500 hospital copay, \$50 ER copay. Eyeglasses - \$45 allowance every 24 months.			
Employee	EE/Spouse	EE/Children	Family
\$296.13	\$576.19	\$536.98	\$872.85

HIP PRIME (20/500/50)			
With RX rider			
\$20 Office Visit Copay except for primary & preventive to age 19. \$20 specialist office visit copayment, \$500 hospital copay, \$50 ER copay, RX Rider - \$100 deductible, \$10 generic/\$20 brand - contraceptives included-formulary required. Eyeglasses \$45 allowance every 24-months.			
Employee	EE/Spouse	EE/Children	Family
\$328.65	\$641.24	\$597.48	\$972.35

HIP PRIME (15/0/35)			
With RX rider			
\$15 Office Visit Copay, \$15 specialist office visit copayment, No hospital copay, \$35 ER copay, RX Rider - \$10 generic/\$20 brand-contraceptives included - \$40 non-formulary. Eyeglasses \$45 allowance every 24-months.			
Employee	EE/Spouse	EE/Children	Family
\$355.09	\$694.14	\$646.67	\$1,053.27

HIP PRIME (10/0/35) with Riders			
RX, Durable Medical Equipment, Private Duty Nursing, and Optical			
\$10 Office Visit Copayment. No hospital copay, \$35 ER copay, DME \$50 ded - appliances in full, PDN 80% (73-504 hrs), optical \$45 allowance every 24 months, RX \$10 generic/\$20 brand, contraceptives included - \$40 non-formulary.			
Employee	EE/Spouse	EE/Children	Family
\$361.76	\$707.49	\$659.08	\$1,073.67

Rates and Benefits are for comparative purposes only. Actual rate and benefit information must come directly from the insurance carrier.

In network benefits include: Preventive dental
The above rates include a \$16 administrative fee
Rates are subject to NY State Insurance Department and carrier approval

IRBA

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

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 \$~~35~~⁵¹.00 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 REGISTERED BUREAU OF ASSOCIATED INSURANCE
Administrators for Business

GROUP APPLICATION for HIP

Company Name: _____

Address: _____

Company Phone # _____ Type of Business _____

Contact: _____ Title: _____

Total Number of Employees: 1

Total Number of EE's Working 20 hours or more per week: 1

Total number of eligible employees: 1

Total number of subscribers enrolling: 1

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 with a personal check must be accompanied with proof of business (ex: Schedule C, NYS-4, 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. Premium includes a \$16 monthly billing fee for plan administration provided by National Administrators.

Plan Applied For (check ONE plan)

HIP (HMO Only)

Plan 1 - PRIME VALUE (20/500/50) HMO - NO RX _____

Plan 2 - PRIME (20/500/50) HMO with RX _____

Plan 4 - PRIME (15/0/35) HMO - with RX _____

Plan 5 - PRIME (10/0/35) with RX _____

All premiums include a \$16 monthly administration fee and must be made payable to "National Administrators, Inc." as administrators for HIP or check will be returned.

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. I understand all current employees have the option of joining HIP now, or on my group's annual anniversary date.

Signature of Owner/Partner

Date

Sonny Henning

Representative
888-766-6932

Representative's Phone Number

HIP Through IRBA -- Premium Quote Sheet

Name of Company: _____
 Effective Date Requested: _____

PLAN SELECTIONS

(CHECK ONE)

- HIP PRIME VALUE (20/500/50) *no* RX - Plan 1
- HIP PRIME (20/500/50) *with* RX - Plan 2
- HIP PRIME (15/0/35) *with* RX - Plan 4
- HIP PRIME (10/0/35) *with* RX - Plan 5

Status	Number of Insured	X	Premium Quote = TOTAL
Single	_____	X	\$ _____
Emp/Spouse	_____	X	\$ _____
Emp/1 Child	_____	X	\$ _____
Family	_____	X	\$ _____

TOTAL DUE _____

(As administrator of plan, please make premium check payable to National Administrators)

Sonny Henning
 Broker Name

[Signature]
 Broker Signature

Date _____
 Phone 888-766-6932

GMA USE ONLY

CODE#: _____



First National Administrators
 Affiliated Companies

American Group Administrators • Greater Metro Agency • IRBA
 The Lynch Group • National Administrators

CERTIFICATION OF SOLE PROPRIETOR STATUS FOR COVERAGE WITH HIP HEALTH PLAN OF NEW YORK

_____ hereby affirm that I
Printed Name

am self-employed, on a full time basis, working 20 or more hours a week. As proof of my employment status, I have enclosed a copy of my most recent federal tax return (which includes a completed schedule C). I agree to notify HIP Health Plan of New York (hereinafter, "HIP") immediately if my circumstances change and I am no longer self employed.

I acknowledge and agree that it is a fraudulent act subject to criminal and civil penalties to knowingly and with intent to defraud file an application for insurance (including any supporting certifications) containing any materially false information, or which conceals for the purpose of misleading, information concerning any fact material thereto. I further acknowledge and agree that filing a false or misleading insurance application with HIP or failing to notify HIP if I am no longer self employed shall render any health insurance contract entered into with HIP null and void.

I certify that this certification and my enclosed federal tax return are true, correct and complete.

SIGNATURE -

Subscriber/Member Enrollment Form

Last Name		First Name		M.	Sex	Social Security Number	
Street Address		Age	City	State		Zip Code	
Were you ever a member of HIP? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, indicate policy number(s):		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced	Birth Date Mo. Day Yr.	Telephone # Home () Work ()		F-Mail Address:	
Primary Care Physician <small>(Not required for HMO/POS)</small> Physician Name	OB/GYN Selection: <small>(Not required for HMO/POS)</small> Physician Name	Qualifying Event: <input type="checkbox"/> Sub/Absorption <input type="checkbox"/> Marriage <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> New Hire		Qualifying Event Date: Mo. Day Yr.		Are you covered by any other Health Insurance or Medicare? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, indicate: Insurance Co. Name _____ Insurance Co. Telephone # _____ Type of Coverage: _____ Policy # _____ Effective Date: ____/____/____	
In your spouse covered by any other Health Insurance or Medicare? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, indicate: Insurance Co. Name _____ Insurance Co. Telephone # _____ Type of Coverage: _____ Policy # _____ Effective Date: ____/____/____		Are you covered by any other Health Insurance or Medicare? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, indicate: Insurance Co. Name _____ Insurance Co. Telephone # _____ Type of Coverage: _____ Policy # _____ Effective Date: ____/____/____					
Prior Health Insurance Information Carrier Name _____ Coverage Begin Date ____/____/____ Coverage End Date ____/____/____		Prior Health Insurance Information Carrier Name _____ Coverage Begin Date ____/____/____ Coverage End Date ____/____/____					
* If you are enrolling for your spouse and/or children, please list each one below - see Election of Coverage for eligibility							
Last Name (if different)		First Name		Soc. Sec. No.	Sex	Relationship	Birth Date Mo. Day Yr. <input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Other
Prior Health Insurance Information		Carrier Name		Coverage Begin Date ____/____/____		Coverage End Date ____/____/____	
Prior Health Insurance Information Carrier Name _____ Coverage Begin Date ____/____/____ Coverage End Date ____/____/____		Prior Health Insurance Information Carrier Name _____ Coverage Begin Date ____/____/____ Coverage End Date ____/____/____					
Prior Health Insurance Information Carrier Name _____ Coverage Begin Date ____/____/____ Coverage End Date ____/____/____		Prior Health Insurance Information Carrier Name _____ Coverage Begin Date ____/____/____ Coverage End Date ____/____/____					
Prior Health Insurance Information Carrier Name _____ Coverage Begin Date ____/____/____ Coverage End Date ____/____/____		Prior Health Insurance Information Carrier Name _____ Coverage Begin Date ____/____/____ Coverage End Date ____/____/____					
Prior Health Insurance Information Carrier Name _____ Coverage Begin Date ____/____/____ Coverage End Date ____/____/____		Prior Health Insurance Information Carrier Name _____ Coverage Begin Date ____/____/____ Coverage End Date ____/____/____					
Your signature is required to process this form. Your signature attests that you have read the reverse side of this form							
Applicant must sign here:				Date			
This Section to be Completed by Employer/Contractor Group							
Name of Group		Group Number		Select One: <input type="checkbox"/> HIP PRIME HMO <input type="checkbox"/> HIP Access I <input type="checkbox"/> HIP PRIME EPO <input type="checkbox"/> HIP PRIME POS <input type="checkbox"/> HIP Access II <input type="checkbox"/> HIP PRIME PPO			
Requested Effective Date	H-W Date	Employer Title	Date Submitted to HIP	Approved by <small>(Representative of Benefits Administrator)</small>		Type of Coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Child	
Instructions to Benefit Administrator or Group Representative: For Groups with 50 employees or less, you MUST complete Section A on the reverse side of this form. Required documentation MUST be attached to this Enrollment Form to be processed.				PROCESSED BY	RECEIVED DATE	PROCESSED DATE	

HIP HEALTH PLAN OF NEW YORK, P.O. Box 2806, New York, NY 10116-2806

ELECTION OF COVERAGE

I am enrolling for coverage for myself, my spouse and unmarried children under 19 years of age and unmarried children under the age limit shown on the group schedule of benefits who are full time students at an accredited educational institution and who are dependent on me and/or my spouse for support.

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 HIP.

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 be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

HIP PRIME POS and HIP Access II applicants please note that your benefits are provided under two separate contracts: a HIP, HMO contract issued by the Health Insurance Plan of Greater New York and HIP PRIME POS and HIP Access II contract issued by the HIP Insurance Company of New York. Both contracts will end simultaneously if your HIP PRIME POS or HIP Access II coverage ends.

The following paragraph pertains to small business groups only.

I understand that pre-existing conditions will not be covered during the first 12 months of my enrollment under my group's contract. A pre-existing condition is a condition (whether physical or mental) regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended by a duly licensed medical professional or received within the six (6) month period ending on the enrollment date. Except that, pregnancy is not considered a pre-existing condition and genetic information may not be treated as a pre-existing condition in the absence of a diagnosis of the condition related to such genetic information. HIP will credit the time I/we were covered by the previous policy, provided that the break in coverage under this plan does not exceed sixty-three (63) days, exclusive of any waiting periods. I agree that after enrolled, I will upon request provide HIP and/or my medical group with information on pre-existing conditions and any previous coverage I had. Subject to the 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 my effective date under my group's contract.

SECTION A

(To be completed by Benefits Administrator)

DOCUMENTATION BASED ON GROUP SIZE

ACTION Check (✓) One	Qualifying Event	Documentation Required	Group Type (Check One) →		
			Sole Proprietorship or One Subscriber Group	Association or Two or More Employees or MEWA'S	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 # and the employee's current year W4 form.	Not Eligible		
<input type="checkbox"/> Add Spouse	Marriage	Marriage Certificate			
<input type="checkbox"/> Add Dependent	Birth	<input type="checkbox"/> Birth Certificate or			
	Adoption	<input type="checkbox"/> Formal Adoption Papers or <input type="checkbox"/> Court Approved Guardianship Papers			
<input type="checkbox"/> Add Spouse	Loss of Coverage	Certificate of Creditable Coverage			
<input type="checkbox"/> Add Dependent					

Note: No Retroactive Enrollments will be allowed. Members must be enrolled within 30 days from the Qualifying Event.