

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.**



IRBA MDNY 2004
HEALTH CARE

**EFFECTIVE
1/1/04***

Nassau and Suffolk County

*Rates effective 1/1/2004 through 12/31/04. This is for comparative purposes only.
For further details please see plan summary.*

*** Rates Approved by the NY State Dept. Of Insurance**

Plan #1 MD FLEX HMO-Flex Provider Network

\$20 Office Visit Copay, \$125 day/ \$500 Maximum per admission hospital copay, Prescription - \$7 generic/\$15 brand/\$35 Non Formulary. Vision -Annual Exam and up to 45% discount on hardware through Davis Vision. Smart Dent Dental Plan. Dependent covered to age 23.

Single	2 Party	Family
\$385.93	\$770.68	\$1,084.37

Plan # 2 MD "Flex" POS-Flex Provider Network

\$20 Office Visit Copay, \$125 day/ \$500 Max per admission hospital copay, \$1,000/\$2,000 deductible - out of network 70%/30% coinsurance (80th Percentile UCR) - \$5,000/\$10,000 out of pocket max, Prescription-\$10 generic/\$25 brand/50% Non Formulary, Vision - Annual Exam and up to 45% discount on hardware through Davis Vision. Smart Dent Dental Plan. Dependent covered to age 23.

Single	2 Party	Family
\$540.60	\$1086.24	\$1,531.12

Plan #4 MD Flex HMO-Flex Provider Network

\$20 Office Visit Copay, \$125 day \$500 maximum hospital copayment, Prescription - \$7 copay generic/Brand name is **Discount Plan ONLY**. Vision - Annual Exam and up to 45% discount on hardware through Davis Vision. Smart Dent Dental Plan. Dependent covered to age 23.

Single	2 Party	Family
\$335.53	\$667.88	\$938.86

Plan #5 MD "Focus" HMO-Focus Provider Network

\$20 Office Visit Copay, \$125 day \$500 maximum hospital copayment, Prescription - \$7 copay generic/Brand name is **Discount Plan ONLY**. Vision - Annual Exam and up to 45% discount on hardware through Davis Vision. Smart Dent Dental Plan. Dependent covered to age 23.

Single	2 Party	Family
\$288.63	\$572.20	\$803.40

Plan #6 MD "Focus" HMO-Focus Provider Network

\$20 Office Visit Copay, \$125 day \$500 maximum hospital copayment, Prescription - \$10 generic/\$25 brand/50% Non Formulary, Vision - Annual Exam and Davis Vision up to 45% discount on hardware. Smart Dent Dental Plan. Dependent covered to age 23.

Single	2 Party	Family
\$328.14	\$652.82	\$917.55



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): _____

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

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
55 Madison Avenue • Suite 400 • Morristown, NJ 07960 • Phone (973) 285-3333 • Fax (973) 285-3330 • Toll Free (888) 352-7299
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.
The Association for Independent Businesses

GROUP APPLICATION for MDNY

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 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.
8. Members must live or work in the service area. Service area is Nassau or Suffolk Counties

Plan Applied For (check ONE plan)

MDNY

Plan #1 MD Flex HMO _____

Plan #2 MD "Flex" POS _____

Plan #4 MD Flex HMO _____

Plan #5 MD "Focus" HMO _____ ***Focus Network***

Plan #6 MD "Focus" HMO _____ ***Focus Network***

All premiums include a \$16 administrative fee and must be made payable to "National Administrators, Inc." as administrators for MDNY 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 employes have the option of joining MDNY now, or on my group's annual anniversary date.

Signature of Owner/Partner

Sunny Henning

Representative

888-766-6932

Date

Representative's Phone Number



One Huntington Quadrangle, Suite 4001 - Melville, NY 11747
 Phone 1-800-909-1950 - Fax (631) 454-1915

Enrollment Form Change Form

A EMPLOYEE INFORMATION

Employee Name (Last)

(First) (Middle)

Home Phone

Work Phone

Soc. Sec. #

Date of Hire

Address (Street No.)

(City)

(County)

(State) (Zip)

NEW EMPLOYEE CHANGE INFORMATION

Check One

Open Enrollment New Hire

Status Change (complete section D)

COBRA Termination

Renewal plan change Add

Effective Date:

Do you or any of your dependents have coverage under any other medical plan? YES NO

If yes, please provide the information below:

Individual Coverage YES NO

Family Coverage YES NO

Are you or any of your dependents eligible for Medicare or Medicaid? YES NO

Where you covered by another medical/hospital plan within the last 12 months? YES NO

If yes, please provide the information in Section F.

C TYPE OF COVERAGE (Please select one of the following):

ADD DEPENDENT REMOVE DEPENDENT ADDRESS CHANGE NAME CHANGE

EMPLOYEE TERMINATION DATE REINSTATEMENT

CONVERSION (Direct Pay) REASON:

Is Employee currently working at least 20 Hrs/Wk? YES NO

D EMPLOYER INFORMATION

Employee Name

Group Number

Telephone

Billing Account Number

E ENROLLMENT INFORMATION

Name (Last Name) (First) (MI)

Birth Date (MO - Day - Yr)

Social Security No.

Sex

Relation (Spouse, Child, etc.)

Former Health Insurance Coverage (Previous 12 months)

Primary Care Physician (ID # or Name) (Choose for each family member) See insurer Directory

Current Patient

G EMPLOYEE SIGNATURE

Please read the information in the following section carefully and then sign and date the form.

I hereby agree for the benefit of myself and my dependents to accept the terms and conditions of the plan as described in the Summary Plan Description and agree to pay the cost of my coverage as specified in the plan document.

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Relationship to Employer: 001 Spouse, 002 Child, 003 Spouse, 004 Other, 005 Spouse, 006 Legal Guardian

Documentation Required

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Documentation Required

Documentation Required

Documentation Required

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H EMPLOYER AUTHORIZATION

The form must be signed and dated by an authorized company employee.

In signing this form, you certify that the employee is eligible for the plan and that the employee is not currently enrolled in any other health plan.

I hereby authorize the company to provide the employee with the plan as described in the plan document.

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