

# 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 15<sup>th</sup> 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.***



First National Administrators



THROUGH



**Two New Plans Added**  
(Plans 3 & 4)

**August 2003**

## Atlantis Health Plan

**Effective August 1, 2003**

All plans renew August 1, 2004 regardless of effective date.

### 2003 POS Plan One

\$20 Office Visit copayment, \$1,000/\$2,500 deductible, 70%/30% coinsurance, \$3,000/7,500 out of pocket maximum\*, \$250 hospital copayment, 50/50% Eckerd Pharmacy Svcs. (in network only) prescription copayments. Atlantis POS Network.

Emp.	Emp./Spouse	Family
<b>\$307.10</b>	<b>\$614.20</b>	<b>\$888.54</b>

### 2003 HMO Plan Two

\$20 Office Visit copayment, \$250 hospital copayment, 50/50% EPS (Eckerd Pharmacy Services) prescription benefits. In network coverage only. Atlantis HMO Network.

Emp.	Emp./Spouse	Family
<b>\$284.02</b>	<b>\$568.04</b>	<b>\$821.76</b>

### 2003 POS Plan Three NO RX

\$20 Office Visit copayment, \$2,000/\$4,000 deductible, 70%/30% coinsurance, \$5,000/10,000 out of pocket maximum\*, \$0 inpatient hospital copayment, Atlantis POS Network.

Emp.	Emp./Spouse	Family
<b>\$259.37</b>	<b>\$518.74</b>	<b>\$750.44</b>

### 2003 POS Plan Four

\$20 Office Visit copayment, \$2,000/\$4,000 deductible, 70%/30% coinsurance, \$5,000/10,000 out of pocket maximum\*. \$0 Inpatient hospital copayment, 50/50% Eckerd Pharmacy Svcs. (in network only) prescription copayments. Atlantis POS Network.

Emp.	Emp./Spouse	Family
<b>\$295.44</b>	<b>\$590.88</b>	<b>\$854.80</b>

Network can be accessed at [www.atlantishp.com](http://www.atlantishp.com)

\* Does not include deductible.

**ALL Rates and benefits are subject to NY State Insurance Department and Carrier approval.**

**Only available in Five Boroughs - Manhattan, Brooklyn, Queens, Bronx and Staten Island.**

**Dependent Student covered to age 23 with proof of student status.**

RX - The member co-payment is 50% of AHP's contracted rate at retail and mail order.

A \$10 monthly billing fee will be added to your premium and will appear on the first invoice and each subsequent invoice. Rates and Benefits are for comparative purposes only. Actual rate and benefit information must come directly from the insurance carrier.



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): \_\_\_\_\_

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  
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



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

## GROUP APPLICATION for ATLANTIS

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-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 the 25th of the month 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 rates do not include a \$10 monthly billing fee for administration by National Administrators. Billing fee will appear on first invoice and all subsequent invoices.

#### Plan Applied For (check ONE plan)

### ATLANTIS

Plan 1 - \$20 Copay POS \_\_\_\_\_

Plan 2 - \$20 Copay HMO \_\_\_\_\_

Plan 3 - \$20 Copay POS NO RX \_\_\_\_\_

Plan 4 - \$20 Copay POS \_\_\_\_\_

**All premiums must be made payable to "National Administrators, Inc." as administrators for ATLANTIS 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 Atlantis now, or on my group's annual anniversary date.*

Signature of Owner/Partner \_\_\_\_\_

Date \_\_\_\_\_

*Sonny Henning*  
\_\_\_\_\_  
Representative

*888 766-6932*  
\_\_\_\_\_  
Representative's Phone Number

# ATLANTIS HEALTH PLAN <sup>SM</sup>

## Employer Member Enrollment and Physician Selection Application

Mailing Address: 39 Broadway, Suite 1240, New York, NY 10006. • 866-747-8422



Doctors make the difference

### To be Completed by EMPLOYER

(Please Print)

Name of Group (Employer)		Group Number		Contract Plan	
Employee's Effective Date of Coverage		Is individual Covered Under Cobra? Yes No		If Yes, Qualifying Event: Date of Qualifying Event:	
Product Selected:	HMO POS DPLN ACCESS POS	Is Employee Currently Active At Work? Yes No		On Leave of Absence? Yes No Retired? Yes No	
Average No. of Hours Worked Per Week:		Date of Full Time Employment:		Employee Occupation	
Employee Classification: Union Non-Union		Employer Signature: X		Date:	

### To be Completed by EMPLOYEE

(Please Print)

Last Name:		First Name and Middle Initial:	
Street Address:		Apt. No.:	City: Country: State: Zip:
Home Phone: ( )		Business Phone: ( )	
Social Security Number:		Male Female	Birth Date:
AHP Primary Care Physician:		AHP Code:	Is this a New Physician For You? Yes No
AHP OB/GYN Provider: (female Members)		AHP OB/GYN Code:	Is this a New Physician For You? Yes No
Type of Coverage:	Single Family Parent/Child Husband/Wife	Any Other Health Coverage (Including Medicare) While Enrolled With AHP? Yes No	
If yes, Carrier Name:		Social Security Number of Policyholder: Coverage Date(s): to	
Communication Preferred (please Rank in Order from 1-4)		Mail Fax Phone E-Mail (Address)	
Preferred Time/Place of Contact: Day Evening Home Office		Language: English Spanish Russian Chinese (Others)	

### EMPLOYEES Dependent Information

(Please Print)

Spouse's Last Name:		First Name and Middle Initial:	
Social Security Number:		Birth Date: Male Female Date Marriage:	
Spouse's Employer:		Spouse's Occupation: Daytime Phone: ( )	
Any Other Health Coverage (Including Medicare) While Enrolled With AHP? Yes No		If yes, Carrier Name:	
Social Security Number of Policyholder:		Coverage Date(s): to	
AHP Primary Care Physician:		AHP Code:	Is this a New Physician For You? Yes No
AHP OB/GYN Provider: (female Members)		AHP OB/GYN Code:	Is this a New Physician For You? Yes No

Eligible Child's Last Name:		First Name and Middle Initial:	
Social Security Number:		Birth Date: Male Female Age:	
Any Other Health Coverage (Including Medicare) While Enrolled With AHP? Yes No		If yes, Carrier Name:	
Social Security Number of Policyholder:		Coverage Date(s): to	
AHP Primary Care Physician:		AHP Code:	Is this a New Physician For You? Yes No
AHP OB/GYN Provider: (female Members)		AHP OB/GYN Code:	Is this a New Physician For You? Yes No

Eligible Child's Last Name:		First Name and Middle Initial:	
Social Security Number:		Birth Date: Male Female Age:	
Any Other Health Coverage (Including Medicare) While Enrolled With AHP? Yes No		If yes, Carrier Name:	
Social Security Number of Policyholder:		Coverage Date(s): to	
AHP Primary Care Physician:		AHP Code:	Is this a New Physician For You? Yes No
AHP OB/GYN Provider: (female Members)		AHP OB/GYN Code:	Is this a New Physician For You? Yes No

Eligible Child's Last Name:		First Name and Middle Initial:	
Social Security Number:		Birth Date: Male Female Age:	
Any Other Health Coverage (Including Medicare) While Enrolled With AHP? Yes No		If yes, Carrier Name:	
Social Security Number of Policyholder:		Coverage Date(s): to	
AHP Primary Care Physician:		AHP Code:	Is this a New Physician For You? Yes No
AHP OB/GYN Provider: (female Members)		AHP OB/GYN Code:	Is this a New Physician For You? Yes No

If you have additional dependents, please use other enrollment form to provide the necessary information.

In order to help us quickly process this form and avoid delays, please make sure all areas are properly filled out.

I authorize deductions from my earnings for any required contributions; and all health professionals to provide Atlantis Health Plan's, and its contracted professionals, information about health (including mental illness) care advice, treatment or supplies provided to me or my dependents relating to coverage for the purpose of coordinating patient care, evaluating and administering claims for benefits, and for fulfilling Atlantis Health Plan's obligations under state and federal law. I will discuss any questions concerning the plan with Atlantis Health Plan's member services. My signature below affirms eligibility for coverage, and all that information provided is full, complete and true to the best of my knowledge.

Any person who knowingly with intent to defraud any insurance company or other person files application for insurance or statement of claim containing any materially false information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

In the absence of creditable coverage Pre-existing Medical Conditions may not be covered for 12 months from the initial enrollment date.

EMPLOYEE/APPLICANT SIGNATURE: X

Date:

Form AHP/OF/Revised 12-02

ONE COPY: ATLANTIS SECOND COPY: EMPLOYER/MEMBER THIRD COPY: EMPLOYEE