2006 CHECKLIST FOR MEMBER ENROLLMENT

Enclosed you will find the following documentation that must be completed if you wish to receive health insurance through the AAESEP/ Atlantis Health Plan program.

1. **Plan Details –** Please review the Plan details enclosed and determine whether you wish to select the "Healthy HMO" or the "Progressive POS" plan option. You are required to choose one of these two options on your "AAESEP/Atlantis Health Plan Enrollment Form".
2. **AAESEP Membership Application and Agreement –** If you did not enroll in AAESEP membership through the AAESEP web site you must read and fill out this form and include a check in the amount of $25 made payable to: "The American Association of Employees and Self-Employed Persons, Inc.", which represents your annual AAESEP membership dues. AAESEP membership is a pre-requisite for joining the AAESEP/Atlantis Health Plan health insurance program. Your application will be rejected if you are not enrolled. If you send this documentation in prior to your one month anniversary as an AAESEP member, it will be held until this date at which time it will be processed.
3. **AAESEP/Atlantis Health Plan Enrollment Form –** This form is required to be filled out in full in order to register for health insurance.
4. **Health History/Coverage Form –** This form is required to be filled out in full in order to register for health insurance.
5. **Physician Recruitment Form –** Use this form if you want us to attempt to recruit a physician not listed in the AAESEP/ Atlantis Health Plan provider list located at: www.atlantishp.com/search/index.asp.

NOTICE: YOU MUST MEET AAESEP / ATLANTIS ELIGIBILITY REQUIREMENTS TO ENROLL. THESE REQUIREMENTS INCLUDE:

- ✓ **Membership in AAESEP for a period of at least one month prior to registration**
- ✓ **Your home street address must be in Manhattan, Brooklyn, Queens, Bronx or Staten Island**
- ✓ **Please note that your first monthly bill will include a $75 one time set up fee and that your subsequent bills will include a $15 monthly administration fee**

MAIL COMPLETED APPLICATIONS TO:

AAESEP
ATTN: MEMBERSHIP ENROLLMENTS
757 THIRD AVENUE, 23RD FLOOR
NEW YORK, NY 10017

AAESEP MEMBERSHIP APPLICATION AND AGREEMENT

This Membership Agreement ("Agreement") together with the Membership Application attached as Exhibit A, contains the complete terms and conditions that apply to a membership ("Membership") in The American Association of Employees and Self-Employed Persons, Inc. ("AAESEP"), a New York non-profit corporation organized to assist employees in New York and across. By submitting a Membership Application, each member ("Member") acknowledges, agrees and accepts the following terms and conditions:

1 Benefits/Services - AAESEP provides its Members with access to a wide range of benefits and services, a comprehensive and current list of which can be located at the AAESEP web site, www.aaesep.org. AAESEP endeavors to ensure that the benefits and services list is kept current and accurate, and that all of its Members have equal and complete access to relevant services and resources. AAESEP cannot guarantee that any particular benefit or set of benefits will be available to or usable by any particular Member at any particular time.

2 Term and Termination - The term of this Agreement will begin on the date AAESEP accepts your Membership Application either in writing or via the web site in electronic form and will end one year later (the "Initial Term"), unless terminated earlier as set forth herein. Nothing contained herein shall obligate AAESEP to accept any Membership Application. At the end of the Initial Term, this Agreement will automatically renew for successive one-year terms (each a "Renewal Term" and together with the Initial Term, the "Term"), unless either party gives written notice of termination at least thirty (30) days before the commencement of a Renewal Term. Either Party may terminate this agreement without cause by written notice, without refund of any membership dues or fees. Upon termination of this Agreement, Member may no longer be eligible to receive any of the benefits.

3 Dues/Fees - An "Individual" Member has the option of activating and maintaining his/her membership by paying a non-refundable Enrollment Fee upon enrolling and non-refundable Renewal Fees upon commencement of each Renewal Term. "Organizational" Members may activate and maintain their membership in the same manner.

Following is an illustration of the Dues/Fees schedule which the Member shall be obligated to pay AAESEP.

TYPE	DUES/FEES
INDIVIDUAL MEMBERSHIP	$25.00 YEARLY ENROLLMENT/RENEWAL FEE
ORGANIZATIONS (UP TO 50 MEMBERS)	$20.00 PER MEMBER YEARLY
ORGANIZATIONS (UP TO 100 MEMBERS)	$15.00 PER MEMBER YEARLY
ORGANIZATIONS (UP TO 500 MEMBERS)	$10.00 PER MEMBER YEARLY
ORGANIZATIONS (OVER 500 MEMBERS)	$7.50 PER MEMBER YEARLY

All payments shall be made in U.S. dollars (US$) and shall be made without deductions based on any sales, use, value-added or other taxes or withholdings. The Membership Fees/Dues listed do not include any taxes of any kind. AAESEP may, in its sole discretion modify the schedule or amount of annual Membership dues, provide that notice of such change is not made less than sixty (60) days prior to the date on which such change becomes effective. MEMBERSHIP DUES PAID TO AAESEP ARE NOT TAX DEDUCTIBLE.

4 Access to Information - In order to provide Benefits, AAESEP will maintain a database containing each Member's name, address, social security number, email address and Membership status, plus any other information given by Member in filling out their membership profile. AAESEP will only allow third parties to access the database for the purpose of delivering benefits and services.

5 Statement of Benefits - AAESEP is a non-profit organization, not an insurance company. One of our goals is to provide all of our members, throughout the United States, access to affordable healthcare. However, AAESEP makes no represenations about the availability, suitablity, or suffciency of health insuarance for any of our members. You are solely responsible for making decisions regarding your healthcare. The benefits described here and those that appear on our website are for illustrative purposes only. We attempt to summarize key healthcare decision making points provided to us by the insurance companies that work with us. If you choose to enroll in a plan, your benefits are subject to the actual membership agreement you sign with these companies.

6 Disclaimer - Except as expressly set forth in this Agreement, AAESEP provides benefits on an as is, as available basis, makes no representations and warranties, express or implied, regarding the Benefits, and hereby specifically disclaims any and all such representations and warranties.

7 Liability - AAESEP shall not be liable for indirect, incidental, consequential, special or exemplary damages arising from the benefits, any breach of this Agreement or any provision of this Agreement. The liability of AAESEP for any claims arising in connection with this Agreement will not exceed the amount of the Membership Fees/Dues paid by a Member to AAESEP in the year in which the event giving rise to the liability occurs.

8 Notice - Any notice under this Agreement must be sent in writing to AAESEP at 757 Third Avenue, 23rd Floor c/o Roger H. Madon and Associates P.C., New York, NY 10017, or to tyler.malin@aaesep.org, and to Member at the mailing address, email address or fax number shown on the Membership Application. Such notice will be deemed delivered (i) on the delivery date if delivered personally or sent by email or confirmed fax, (ii) one business day after deposit with a commercial overnight carrier with written verification of receipt, or (iii) five (5) business days after the mailing date, whether or not actually received, if sent by U.S. mail, postage prepaid and return receipt requested.

9 Force Majeure - Neither party will be considered in breach of this Agreement on account of any delay or failure to perform as a result of any causes or conditions that are beyond such party's reasonable control and that such party in unable to overcome by the exercise of reasonable diligence.

10 Applicable Law - This Agreement and the legal relations between AAESEP and Member will be governed by and construed in accordance with the substantive laws of the State of New York, without giving effect to the principles of conflict of laws thereof.

EXHIBIT A MEMBERSHIP APPLICATION

I. SELECT A TYPE OF MEMBERSHIP

☐ INDIVIDUAL
☐ ORGANIZATION
HOW MANY MEMBERS ARE IN YOUR ORGANIZATION ______________

II. GENERAL INFORMATION

COMPANY NAME (FOR ORGANIZATIONS) ______________
FULL NAME ______________
SOCIAL SECURITY/EIN ______________
ADDRESS ______________
CITY, STATE, ZIP ______________
EMAIL ADDRESS ______________
PHONE NUMBER ______________

III. PAYMENT INFORMATION (PAY BY CHECK OR ENTER CREDIT CARD INFORMATION BELOW)

CREDIT CARD NUMBER ______________
EXP. DATE ______________
CID NUMBER ______________

VISA, MASTERCARD, DISCOVER: LAST 3 DIGITS ON BACK OF CARD.
AMERICAN EXPRESS: LAST 4 DIGITS IN SMALL PRINT ON FRONT OF CARD

IV. RECURRING BILLING AUTHORIZATION

By signing below, you authorize AAESEP to charge the identified credit card for dues/fees indicated as they become due both during the Initial and any Renewal Terms.

V. SIGNATURE

I have read and understand the terms and conditions of the Membership Agreement with AAESEP, I represent and warrant that the information set forth in this Membership Application is true, correct and complete, and agree to promptly update such information if it changes.

______________ ______________
SIGNATURE DATE

MAIL COMPLETED APPLICATIONS TO: AAESEP, ATTN: MEMBERSHIP ENROLLMENTS, 757 THIRD AVENUE, 23RD FLOOR, NEW YORK, NY 10017

AAESEP/ATLANTIS HEALTH PLAN ENROLLMENT FORM

PLAN OPTION:	☐HMO ☐POS	TYPE OF COVERAGE:	☐SINGLE ☐COUPLE ☐PARENT/CHILD ☐FAMILY

MEMBER INFORMATION

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER

HOME ADDRESS	APT. NO.	CITY	STATE	ZIP CODE

HOME PHONE NUMBER	BUSINESS PHONE	IF MARRIED, DATE OF MARRIAGE

DEPENDENT INFORMATION

	ADD / REMOVE	LAST NAME, FIRST NAME, MI	SEX	DATE OF BIRTH	SOCIAL SECURITY	PRIMARY CARE PHYSICIAN NAME & AHP CODE
AAESEP MEMBER	☐ ☐			/ /		______
SPOUSE	☐ ☐			/ /		
CHILD 1	☐ ☐			/ /		
CHILD 2	☐ ☐			/ /		
CHILD 3	☐ ☐			/ /		
CHILD 4	☐ ☐			/ /		

STUDENT INFORMATION

IF DEPENDENT CHILDREN LISTED ARE AGE 19 OR OLDER, DO THEY ATTEND SCHOOL ON A FULL-TIME BASIS?	IF YES, LIST FIRST NAME OF CHILD AND SCHOOL	IS ANY DEPENDENT DISABLED?
☐YES ☐NO		☐YES ☐NO NAME: ______

NOTE - Documentation will be required from the member to certify the information specific to full time student or disabled dependent.

OTHER INSURANCE INFORMATION

DO YOU, YOUR SPOUSE OR DEPENDENT CHILDREN HAVE OTHER HEALTH INSURANCE?	NAME OF INSURED	NAME OF INSURANCE CARRIER & POLICY NO.
☐YES ☐NO		

GIVE NAME OF PRIOR INSURER AND DATE OF TERMINATION	PROOF OF PRIOR COVERAGE

I authorize deductions from my earnings for any required contributions; and all health professionals to provide Atlantis Health Plans 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 discusss 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 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.

In the absence of creditable coverage Pre-existing Medical Conditions may not be covered for 11 months from the initial enrollment date.

______________________________ ______________________________

EMPLOYEE/APPLICANT SIGNATURE **DATE**

MAIL COMPLETED APPLICATIONS TO: AAESEP, ATTN: MEMBERSHIP ENROLLMENTS, 757 THIRD AVENUE, 23RD FLOOR, NEW YORK, NY 10017

HEALTH HISTORY COVERAGE FORM

Subscriber: To complete the enrollment process, please provide information on any prior health insurance coverage you and/or your dependents have had in the last 12 months is required. Please attach the **"Certificate of Coverage"** from your prior health plan(s) or complete the following.

Within the past 12 months I have had **(check one)**

☐ No Prior Coverage ☐ One Insurance Carrier ☐ Multiple Insurance Carriers

1

INSURANCE CARRIER NAME

POLICY / SUBSCRIBER NUMBER

DATE COVERAGE BEGAN

DATE COVERAGE ENDED

TYPE OF POLICY

☐ DIRECT PAYMENT
☐ GROUP

COVERAGE TYPE

☐ INDIVIDUAL
☐ FAMILY

DEPENDENT(S) NAME(S)

2

INSURANCE CARRIER NAME

POLICY / SUBSCRIBER NUMBER

DATE COVERAGE BEGAN

DATE COVERAGE ENDED

TYPE OF POLICY

☐ DIRECT PAYMENT
☐ GROUP

COVERAGE TYPE

☐ INDIVIDUAL
☐ FAMILY

DEPENDENT(S) NAME(S)

3

INSURANCE CARRIER NAME

POLICY / SUBSCRIBER NUMBER

DATE COVERAGE BEGAN

DATE COVERAGE ENDED

TYPE OF POLICY

☐ DIRECT PAYMENT
☐ GROUP

COVERAGE TYPE

☐ INDIVIDUAL
☐ FAMILY

DEPENDENT(S) NAME(S)

IF ADDITIONAL SPACE IS NEEDED FOR DEPENDENTS, PLEASE COMPLETE A SEPARATE SHEET OF PAPER

TO THE BEST OF MY KNOWLEDGE, THE INFORMATION PROVIDED ABOVE IS TRUE AND COMPLETE. I.E. I UNDERSTAND THAT FAILURE TO COMPLETE THIS FORM MAY RESULT IN DENIED CLAIM PAYMENT FOR SERVICES.

PRINT NAME OF SUBSCRIBER **SIGNATURE OF SUBSCRIBER** **DATE**

MAIL COMPLETED APPLICATIONS TO: AAESEP, ATTN: MEMBERSHIP ENROLLMENTS, 757 THIRD AVENUE, 23RD FLOOR, NEW YORK, NY 10017

MEMBER REQUEST FOR RECRUITING PHYSICIANS FORM

Dear Member:

AAESEP and Atlantis Health Plans are committed to assisting you in finding the best doctors in New York City. If after reviewing the Atlantis Health Plan directory you cannot locate your current doctor or a doctor you wish to see, we encourage you to request that we contact your doctor concerning participation in Atlantis Health Plan. Please complete the form below and return it with your application/enrollment package or fax it to 212-747-0843.

DOCTOR

DOCTOR'S FULL NAME

ADDRESS

PHONE NUMBER

SPECIALTY

HOSPITAL OR CLINIC NAME

YOU

YOUR NAME

YOUR PHONE NUMBER

YOUR EMAIL ADDRESS

MAIL COMPLETED APPLICATIONS TO: AAESEP, ATTN: MEMBERSHIP ENROLLMENTS, 757 THIRD AVENUE, 23RD FLOOR, NEW YORK, NY 10017

FINAL STEPS

Please PRINT AND SIGN your completed....

1 **AAESEP MEMBERSHIP AGREEMENT** (if you have not already registered and paid your annual dues online)

2 **AAESEP/ATLANTIS HEALTH PLAN ENROLLMENT FORM**

3 **HEALTH HISTORY COVERAGE FORM**

4 **PHYSICIAN RECRUITMENT FORM** (optional)

MAIL YOUR COMPLETED APPLICATION PACKAGE ALONG WITH A CHECK, MONEY ORDER, OR COMPLETED CREDIT CARD AUTHROIZATION FORM IN THE AMOUNT CALCULATED AT LINE 4 OF THE FILL-IN FORM BELOW:

1. __________ **ANNUAL AAESEP MEMBER DUES** (ENTER $25.00 HERE IF YOU HAVE NOT ALREADY REGISTERED AND PAID FOR AAESEP MEMBERSHIP ON-LINE)
2. ____$75____ **AAESEP ONE TIME ACCOUNT SETUP AND REGISTRATION FEE**
3. __________ **FIRST MONTHS PREMIUM PAYMENT** (ENTER THE AMOUNT OF THE MONTHLY PREMIUM PAYMENT FOR THE PLAN AND OPTIONS YOU WISH TO SELECT. SEE BELOW FOR DETAILS)

ADD LINES 1,2,3 AND ENTER THE RESULT IN LINE FOUR

4. __________

PLEASE SEND FULL PAYMENT IN THE AMOUNT FOUND IN LINE 4 OF THE ABOVE WORKSHEET WITH YOUR COMPLETED APPLICATION PACKAGE. MAIL YOUR FULLY COMPLETED REGISTRATION MATERIALS INCLUDING YOUR CHECK, MONEY ORDER OR COMPLETED CREDIT CARD AUTHORIZATION FORM TO:

AAESEP
ATTN: MEMBERSHIP ENROLLMENTS
757 THIRD AVENUE, 23RD FLOOR
NEW YORK, NY 10017

HOW TO DETERMINE YOUR MONTHLY PREMIUM PAYMENT

Progressive POS Group Health Plan

1. Point of Service (POS) w/ Open Access (No Referrals Needed)
   a) $20 Co-pay $500 Hospital Co-pay per continuous confinement
   b) 7/30/50 Prescription Rider (no annual deductible or limit)
   c) $2000 Deductible and 70/30 Coinsurance when out of Network

Monthly Cost : Single $291.26 Husband/Wife $582.52 Parent/Child $585.72 Family $896.50

Healthy HMO Group Health Plan

2. Health Maintenance Organization (HMO) w/ Open Access (No Referrals Needed)
   a) $20 Co-pay $500 Hospital Co-pay per continuous confinement
   b) 7/30/50 Prescription Rider (no annual deductible or limit)

Monthly Cost : Single $271.96 Husband/Wife $543.92 Parent/Child $546.91 Family $837.09