Print Form

ATLANTIS HEALTH PLAN

INSTRUCTIONS FOR ENROLLMENT

1. In order to enroll and maintain eligibility, you must be a current member of The Business Council of Westchester.

2. Return all original applications, first months' premium and other required information to The Business Council of Westchester's Atlantis Health Plan representative:

Marc Neuburger
40 Exchange Place
Suite 2010
New York, NY 10005
(914) 953-1750
Mneuburger@atlantishp.com

3. The following must be submitted by the 20th of the month, to be enrolled by the 1st of the following month:

    A. Employer Member Enrollment Form including your selected Physician
    B. A check for the first month's premium payable to Atlantis Health Plan
    C. Credit Card/Bank Draft authorization form
    D. Atlantis Group Agreement form
    E. Proof of business/eligibility (any one of the following):
        1. NYS 45
        2. Certificate of business & payroll documentation
        3. Proof of minimum annual income of $10,000 in form of Schedule C or 1099

To find an in-network physician, visit Atlantis Health Plan's website at www.atlantishp.com.

THE BUISNESS COUNCIL OF WESTCHESTER
TERMS & CONDITIONS

1. The employer must be a member of The Business Council of Westchester or join the Chamber prior to enrollment.

2. All payments are to be made to Atlantis Health Plan. All applications must be submitted with a check and be accompanied by proof of business.
   Example: Schedule C, NYS45, Certificate of Business, etc.

3. A minimum annual gross income of $10,000 is required.

4. Applications for enrollment won't be approved if they are not properly completed, and accompanied by premium payment made payable to Atlantis Health Plan.

5. Future premiums must be received before the 1st of the following month to avoid termination.

6. A copy of your HIPPA form, present carrier bill or copy of your current insurance card must be included. (if applicable)

7. All applications and supporting material are required by the 20th of the month.
   All premiums must be made payable to Atlantis Health Plan or checks will be returned.

The information provided in this application is true and correct to the best of my knowledge. I understand that coverage and benefits may be affected by failure to provide complete and accurate information. I understand that all current qualified employees have the option of joining Atlantis Health Plan now or on my group's annual anniversary date.

_____ _____

Signature of Enrolling Firm Benefit Administrator

_____ _____

Date Date