New York, NY 10006

Employer Group Application

180 East Main Street, Suite. 205
Patchogue, NY 11772
1-800-427-5358

Company Name:____

Company Address:____

____

Company Phone:______________________________

Business Type:____

Contact/Plan Admininstrator:____

Title:____

Total Number of Employees:____________

Employees Working 20 hours or more weekly:____________

Total Number of Eligible Employees:____________

Total Number of Employees Enrolling:____________

Number of: **Single**_______ **Emp./Spouse**_______ **Emp./Child**_______ **Family**_______

Current Carrier (if applicable):____

Coverage Effective Date:_______________ **Coverage Termination Date:**_______________

Requested Effective Date:_______________ **Employer Waiting Period:** ❑ **0** ❑ **30** ❑ **60** ❑ **90** ❑ **1yr**

Be sure to make premium checks payable to: **ELITE PROGRAMS, INC.** to avoid a delay in processing

PLAN SELECTION *(Check One - Please Refer to Rates/Plan Descriptions)*

- ❑ Plan **1** AHP-POS-GRP-B10
- ❑ Plan **2** AHP-POS-GRP-A20E
- ❑ Plan **3** AHP-POS-GRP-E20E
- ❑ Plan **4** AHP-POS-GRP-E20
- ❑ Plan **5** AHP-HMO-GRP-Low Option
- ❑ Plan **6** AHP-HMO-GRP-Low Option/Generic Rx
- ❑ Plan **7** AHP-POS-GRP F20/Generic Rx

The information provided above 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 employees have the option of joining Atlantis Health Plan now or on my group's anniversary date.

______________________________ Signature of Owner/Partner

______________________________ Signature of Broker/Agent Representative

______________________________ Date

______________________________ Broker/Agent Phone