

ATLANTIS HEALTH PLAN, INC.

Business Council of Westchester Chamber Group Agreement Form

Group Administrator: _____

Group Name: _____

Group Number: _____

Effective Date: _____

Tax ID #: _____

In consideration of the payment of Premiums in accordance with the terms and provisions of this Group Agreement Form, Atlantis Health Plan, Inc. ("Atlantis") shall hereby arrange or pay for medical and hospital services in accordance with the terms and provisions of the Subscriber Contract for Subscribers and their Covered Dependents ("Members"). Terms not defined herein shall have the meaning set forth in the Subscriber Contract.

I. Effective Date and Term of Agreement:

This Agreement shall be effective on the _____ day of (month/year) _____ at 12:00 a.m. Eastern Time and will remain in effect for a period of _____ consecutive Months, ending on the _____ day of (month/year) _____ at 11:59 p.m. Eastern Time at which time coverage provided pursuant to the Subscriber Contract will be renewed automatically for one (1) year periods thereafter unless written notice of cancellation has been given by either party as set forth in Section XIII of this Agreement.

II. Coverage - Plan Design:

Plan A

Plan B

Plan C

Plan D

Plan E

Plan F

III. Premium Rate Schedule

Type of Coverage	Total Monthly Premium
Single	\$ _____
Husband/Wife	\$ _____
Parent/Child(ren)	\$ _____
Family	\$ _____

IV. Eligibility:

Eligible members must reside or live in the Service Area or work in the Area and receive all covered health care there. In addition, eligible subscribers and their eligible family members shall meet the eligibility criteria set forth in the Subscriber Contract. Coverage ends on the last day of the month premium covers.

*Waiting Period _____ days/months from date of hire.
(Eligible the first of the month following waiting period).

Subscriber (employee) coverage ends on the last day of the month that employment ends.

Family Members are spouse and dependent children until child reaches age 19, or age 23 if enrolled as a full-time student at an accredited educational institution. Coverage ends on the last day of the month in which the child's birthday occurs.

Eligibility will be restricted to an individual or small group where the individual or small group has had coverage terminated within the previous twelve (12) months for non-payment of premiums per Section 360.3(11) of Regulation 145.

V. Notice:

Any notice hereunder to be given to Group Administrator shall be addressed to

Attn: _____

Address: _____

City, State, Zip: _____

Telephone#: _____

Fax#: _____

E-mail: _____

Any notice hereunder to be given to Atlantis shall be addressed to:

Atlantis Health Plan, Inc.
45 Broadway, Suite 300
New York, NY 10006

VI. Premium Due Date and Payments:

The first day of a month of coverage hereunder is the "Premium Due Date". The Group Administrator agrees to remit to Atlantis on or before the Premium Due Date the applicable Total Monthly Premium set forth in Section III above for each Subscriber and Covered Dependent enrolled as of such date as determined by Atlantis by reference to Atlantis member records. If such Premium payment is not made in full by Group on or prior to the Premium Due Date, a thirty (30) day Grace Period shall be granted to Group for payment without interest charge. If payment is not received by the expiration of the Grace Period, then Atlantis pursuant to Section XIII may terminate this Agreement.

If this Agreement is terminated for any reason, Group Administrator shall continue to be held liable for all Premium payments due and unpaid before termination, including, but not limited to, Premium payments for any time this Agreement is in force during the Grace Period. Notwithstanding any language to the contrary in this Agreement or the Subscriber Contract, Atlantis shall have no obligation to provide benefits or pay claims for any Member during any period for which the required Premium payment has not been made (except during any Grace Period). If Atlantis does provide benefits or pay claims for any Member during any period for which the Premium payment has not been made, such provision of benefits or payment of claims shall not constitute a waiver of Atlantis' rights to discontinue the provision of coverage or payment of claims until such time as the Premium payment is made.

VII. Premium Rate Changes:

The Premium Rate Schedule set forth on page one of this Agreement shall be valid only for the Initial Contract Period. If Atlantis elects to offer coverage to the Group for any Subsequent Contract Period after the Initial Contract Period, Atlantis may change the Premium Rate Schedule for any Subsequent Contract Period. Atlantis will give Group at least forty-five (45) days advance notice of the Premium Rates for each Subsequent Contract Period. If Atlantis fails to give Group such forty-five (45) days advance notice, the Premium Rates in effect prior to the commencement of the Subsequent Contract Period shall remain in effect for a period of forty-five (45) days after the Group was notified by Atlantis of the new Premium Rates for the Subsequent Contract Period, after which period the new Premium Rates will go in to effect. Under no circumstances shall Atlantis' failure to provide forty-five (45) days advance notice of new Premium Rates obligate Atlantis to continue coverage for the Group beyond the end of the Initial Contract Period or a Subsequent Contract Period as the case may be. At any time, with a forty-five (45) day notice, Atlantis may change the premium schedule for any subsequent contract period when a change required by statute or regulation increases Atlantis' risk under the agreement.

VIII. Member Effective Dates of Coverage:

Coverage of prospective Subscribers and Covered Dependents shall be subject to receipt by Atlantis of Enrollment Form for each prospective Subscriber and Covered Dependant within thirty-one (31) days of each Subscriber or Covered Dependant becoming eligible for coverage under this Agreement, together with receipt of the monthly Premium for such Subscriber or Covered Dependent as applicable.

IX. Ineligible Members:

If, upon a Member becoming ineligible, Group Administrator fails to immediately notify Atlantis of such Member's termination, and Group Administrator has made or continues to make the Premium payment specified herein for such Member, such Premium payment will only be credited by Atlantis to Group back to the last day of the month immediately prior to the month in which such termination notice is received by Atlantis, provided Atlantis has not authorized or incurred claims for health services for such Members after such Member became ineligible, but before Atlantis received a proper disenrollment notification from the Group with respect to such Member's termination.

X. Annual Renewal

The Group Administrator shall hold an annual renewal meeting at least once each year at which time the group and eligible members, as determined by this Agreement and the Subscriber Contract, may elect changes under this Agreement.

XI. Responsibilities of Group:

Group agrees to:

- A. Offer coverage to eligible members and their family members, as described in Section IV above. It is understood that eligible members of a Group shall be free to choose either Atlantis coverage or such other coverage as may be available through the Group during both the initial and subsequent Group Open Enrollment Periods. Every eligible member of the Group shall be given a fair opportunity to elect one of such options over the other and shall not be penalized by the Group because of such a choice, other than through differential payroll deductions as may be indicated by premium variations from insurer to insurer.
- B. Offer each new member the opportunity to elect Atlantis coverage as a procedure of employment when such person attains the status of an eligible member as provided in this Agreement.
- C. Provide notification to each Member, within fifteen (15) days after termination of the Member's coverage, of the Member's right to convert to an Atlantis individual direct payment contract, and the duration of such conversion coverage.
- D. Furnish to Atlantis, on a monthly basis on Atlantis approved forms, such information as may reasonably be required by Atlantis for the administration of Atlantis' prepaid program and coverage provided hereunder, including any change in a Member's eligibility status. In addition, Atlantis may, at reasonable times, examine the group administrator's pertinent records with respect to eligibility and premium payments hereunder. Per the employee's signature on the Atlantis enrollment application, the member agrees to allow the group to remit membership information to Atlantis Health Plan.
- E. Comply with all policies and procedures established by Atlantis in administering and interpreting this Agreement and communicated to Group Administrator by Atlantis.
- F. Furnish all Member enrollment and termination/change notification to Atlantis solely on Atlantis enrollment and termination forms within the time periods required by this Agreement.

XII. Termination:

- A. Except as otherwise provided by applicable Law, this Agreement and the coverage provided hereunder may be terminated by Atlantis:
 1. In the event that the policyholder or a participating entity has failed to pay premiums or contributions in accordance with the terms of the contract as set forth in Section VI of this Agreement, or Atlantis has not received timely premium payments.
 2. In the event that the policyholder or a participating entity has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Contract, upon not less than one month's prior written notice.
 3. Upon discontinuance of this class of HMO contract upon not less than five (5) months' prior written notice. In exercising the option to discontinue coverage, Atlantis shall act uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for such coverage and shall give the option to purchase all other individual health insurance coverage currently being offered by Atlantis to applicants in that market.
 4. Upon discontinuance of all hospital, surgical or medical expense insurance contracts for which the premiums are paid by a

remitting agent of a group, in the small group market, or the large group market, or both markets, in this state. Written notice shall be given to the Superintendent and to each subscriber not less than one hundred eighty days (180) prior to the date of the expiration of such coverage. In the event of such a withdrawal, the Corporation must also provide the Superintendent with a written plan to minimize potential disruption in the marketplace occasioned by such withdrawal. In addition, Atlantis may not provide for the issuance of any hospital, surgical or medical expense coverage in such market in this state during the five-year period beginning on the date of the discontinuance of the last health insurance coverage not so renewed.

5. The policyholder ceases to meet the requirements for a group under Section 4235 of the Insurance law, or a participating employer, labor union, association or other entity ceases membership or participation in the group to which this Agreement is issued. Termination shall be done uniformly without regard to any health status-related factor relating to any covered individual.

6. Pursuant to this network Plan, there is no longer any enrollee in connection with such Plan who lives, resides or works in the Atlantis Service Area for which the corporation is authorized to do business.

7. Upon written notice, if the Group ceases to operate or relocates outside the Service Area; or

8. Such other reasons as the Superintendent may approve and authorized by the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and any later amendments or successor provisions, or by any federal regulations or rules that implement the provisions of the Act, upon not less than one month's prior written notice.

- B. Except as otherwise provided by applicable Law, this Agreement and the coverage provided hereunder may be terminated by the Group upon one month's prior written notice of termination.

XIII. Amendments:

Any amendments to this Agreement shall be in writing and must be approved and authorized by representatives of both the Group Administrator and Atlantis. No other individual has the authority to modify this Agreement, waive any of its provisions or restrictions, extend the time for making a payment, or bind Atlantis by making any other commitment or representation.

Formal acceptance of an amendment to this agreement by the Group Administrator shall not be required: if the change has been negotiated by means of a request by the Group Administrator and agreed to by Atlantis; if the change is required to bring the Agreement into conformance with any applicable law, regulation or ruling of the jurisdiction in which the Agreement is delivered or of the federal government; or if the Group Administrator makes payment of any applicable Premium on or after the effective date of such amendment.

XIV. Entire Agreement:

This Agreement, the Member Enrollment Application of each member, and the Subscriber Contract constitute the entire agreement between the parties and supersedes all prior and contemporaneous arrangements, understandings, negotiations and discussions of the parties with respect to the subject matter hereof, whether written or oral; and there are no warranties, representations, or other agreements between the parties in connection with the subject matter hereof, except as specifically set forth herein. No supplement, modification or waiver of this Agreement shall be binding unless executed in writing by authorized representatives of the parties.

XV. Applicable Law:

The laws of the State of New York shall govern this agreement.

XVI. Inconsistency:

In the event of any inconsistency between this Group Agreement Form and the Subscriber Contract, the terms of this Group Agreement Form shall govern.

Community Rates:

New York State requires HMOs to charge Groups premium rates that are consistent from one Group of the same type to another. This concept is called Community Rating. Atlantis does not base the premium your Group is charged on the actual cost of providing services to your Group alone, but an average of all Groups which fit into the same category as yours. Atlantis may, of course charge different premiums for different benefit packages. Atlantis may also, if we so choose, develop premiums that vary by certain factors such as group size.

Because all HMOs are required to get approval by the New York State Department of Insurance for each benefit package and rider for a specific time period, the HMO is also required to charge and collect premiums equivalent to that approved rate. There are a number of factors, which could impact whether or not your Group is being charged the approved premium rate:

- Timing of Premium Rate Quote;
- The Period which the Premium Rate Quote is different than the community rating period;
- Rate adjustments required due to an over- or undercharge for a prior period.

Group Information

Authorized Signature: _____

Title: _____

Date: _____

Number of Full-Time Employees _____

Number of Part-Time Employees _____

Number of Employees Eligible for Health Insurance Benefits _____

Broker/ Sales Agent Information

1. Full legal name of firm/Agent: _____

2. Address of firm/Agent: _____

3. Contact: _____

4. Telephone No. _____

5. SS # or Fed. Tax ID# _____

6. Broker/Agent ID Codes: _____

ATLANTIS HEALTH PLAN, INC.

Authorized Signature: _____

Title: _____

Date: _____

General Agent Information

1. Full legal name of firm: _____

2. Address of firm: _____

3. Contact: _____

4. Telephone No. _____

5. SS # or Fed. Tax ID# _____

6. GA ID Codes: _____

I acknowledge that my Atlantis Health Plan identification cards may not be received by the 1st day of my effective month. However, I understand that I will be covered the 1st day of my effective month.

Applicant Signature

Date

PREVIOUS INSURANCE COVERAGE FORM

Subscriber: To complete the enrollment process, 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 last 12 months I have had: *(check one)*

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

Subscriber Insurance Carrier Name:		Policy/Subscriber Number:	
Date Coverage Began:		Date Coverage Ended:	
Type of Policy:	<input type="checkbox"/> Group	<input type="checkbox"/> Direct Payment	
Coverage Type:	<input type="checkbox"/> Family	<input type="checkbox"/> Individual	
Spouse Insurance Carrier Name:		Policy/Subscriber Number:	
Date Coverage Began:		Date Coverage Ended:	
Type of Policy:	<input type="checkbox"/> Group	<input type="checkbox"/> Direct Payment	
Coverage Type:	<input type="checkbox"/> Family	<input type="checkbox"/> Individual	
Dependent Insurance Carrier Name:		Policy/Subscriber Number:	
Date Coverage Began:		Date Coverage Ended:	
Type of Policy:	<input type="checkbox"/> Group	<input type="checkbox"/> Direct Payment	
Coverage Type:	<input type="checkbox"/> Family	<input type="checkbox"/> Individual	
Dependent Insurance Carrier Name:		Policy/Subscriber Number:	
Date Coverage Began:		Date Coverage Ended:	
Type of Policy:	<input type="checkbox"/> Group	<input type="checkbox"/> Direct Payment	
Coverage Type:	<input type="checkbox"/> Family	<input type="checkbox"/> Individual	

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 understand that failure to complete this form may result in denied claim payment for services.

Print Name of Subscriber

Signature of Subscriber

Date

