



## ENROLLMENT CHECKLIST

*Please review the checklist below before you send your Enrollment Application*

PLEASE PRINT CLEARLY AND USE BLACK INK TO COMPLETE APPLICATION

- Applicant must complete page 1 and page 2 of the enrollment application
- Application must be received by the 10th of prior month to be approved for the 1st of the following month or it must be received by the 25th of the prior month to be approved for the 15th of the following month.
- Paying via check: Make check payable to **Insurance Resource Group**
- Paying via EFT: Include a legible copy of a voided check
- Mail or Email Completed Application to:

**CNY Financial Group  
432 N Franklin Street Ste 50  
Syracuse, NY 13204**

**[mpw@cnyfinancialgroup.com](mailto:mpw@cnyfinancialgroup.com)**

# AIM Stand Alone Enrollment:

Name of Group:		Agent Name:	
Effective Date:	Date Submitted:		

**SECTION I — Enrollment Form - FORM MUST BE FILLED OUT IN BLACK BALLPOINT INK - PLEASE PRINT CLEARLY**

**APPLICATION TYPE**  
(Check Appropriate Box)

ENROLLMENT       ENROLLMENT CHANGE       TERMINATION

**LEVEL OF COVERAGE**  
(Check Appropriate Box)

SINGLE       HUSBAND & WIFE       FAMILY

**SELECT MEDICAL PLAN**  
(Check Appropriate Box)

AIM Rx Card       \$10,000 Critical Illness

		REQUESTED EFFECTIVE DATE FIRST DAY of (MM/YYYY)	
APPLICANT NAME (Last, First, Middle Initial)	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	BIRTHDATE (mm/dd/yyyy)	SOCIAL SECURITY NUMBER
STREET ADDRESS	CITY	STATE	ZIP CODE
BILLING ADDRESS / CONTACT / COMPANY (If different than above)			EMAIL ADDRESS
HOME TELEPHONE	WORK TELEPHONE	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	DATE of EVENT (If Applicable)

Note: If you are applying for coverage for your spouse and/or children, please list each one below - see Election of Coverage for eligibility. Please indicate additional dependents on a duplicate sheet.

LAST NAME	FIRST NAME	RELATIONSHIP	GENDER	SOCIAL SECURITY NUMBER	BIRTHDATE (mm/dd/yyyy)	Check if over 19 & disabled?	TERM LIFE BENEFICIARY
SPOUSE		<input type="checkbox"/> WIFE <input type="checkbox"/> HUSBAND	<input type="checkbox"/> Male <input type="checkbox"/> Female				
DEPENDENT		<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	<input type="checkbox"/> Male <input type="checkbox"/> Female				
DEPENDENT		<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	<input type="checkbox"/> Male <input type="checkbox"/> Female				
DEPENDENT		<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	<input type="checkbox"/> Male <input type="checkbox"/> Female				
DEPENDENT		<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	<input type="checkbox"/> Male <input type="checkbox"/> Female				

Are you covered by any other health insurance plan?  YES  NO


**ELECTION OF COVERAGE AND AUTHORIZATION\***

The applicant in consideration of membership in the Association and participation in the plan hereby acknowledges that the Association, its third party administrator, their agents, owners, successors and assigns assumes no liabilities or obligations other than those specifically identified. I hereby agree to indemnify them from and against any and all claims, damages, losses, costs or expenses (including, without limitation, attorneys fees and disbursements) for any claims that may arise by the participation of the plan or membership in the association. I understand that pre-existing conditions will not be covered during the first 12 months of the contract unless I present evidence of prior creditable coverage. All information provided above is true and complete 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, shall be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation. **Disclaimer IMPORTANT!** Our medical plan is a low-cost alternative, providing medical insurance at fixed amounts, and these **limited benefits** are paired with medical discounts to designated providers. My signature below indicates that the limitations of the plan have been disclosed & explained to me and that I understand and accept said plan designs. My signature below also indicates I would like to enroll in the limited medical health plan I selected above. All applicants must sign below. Any false statement will be cause for immediate cancellation of coverage. **It will take one week after your effective date for your cards and provider books to arrive.**

APPLICANT SIGNATURE (REQUIRED) <b>X</b>	DATE
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**ACCEPTANCE AND AGREEMENT NOTICE:** Submission of Employer Application does not initiate coverage. Coverage is subject to approval prior to initiation. Enrollees will be issued individual policies and/or certificates of insurance. Minimum participation may be required. In the event that participation is not met, coverage will not take effect. Your coverage will begin on the first day of the month following receipt of the Enrollment Form. This is a limited benefit policy and is not a substitute for a major medical plan.

APPLICANT SIGNATURE (REQUIRED) <b>X</b>	PRINT NAME	DATE
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**AIM Stand Alone Plans —**

**ENROLLMENT FORM (PAGE 2)**

Rep Name:	Rep Signature <b>X</b>	Date	Telephone:	Rep Code:
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**SECTION IV — BILLING FORM - FORM MUST BE FILLED OUT IN BLACK BALLPOINT INK - PLEASE PRINT CLEARLY**

<p><b>SELECT MONTHLY PREMIUM</b></p> <p>Individual Only      <input type="checkbox"/> \$12.50      <input type="checkbox"/> \$32.00</p> <p>Husband &amp; Wife      <input type="checkbox"/> \$18.00      <input type="checkbox"/> \$52.00</p> <p>Family      <input type="checkbox"/> \$26.00      <input type="checkbox"/> \$55.00</p>	<p><b>CALCULATE MONTHLY PREMIUM</b></p> <p>Step 1. Enter Premium Selected:      \$ _____</p> <p>Step 2. One Time Enrollment Fee:      \$25.00</p> <p>Step 3. Total Contribution at Enrollment — Add Steps 1 &amp; 2      \$ _____</p>
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**PAYMENT OPTIONS** (Check Appropriate Box Below)

- CHECK OR MONEY ORDER (**Make payable to Insurance Resource Group. There is a \$30 insufficient funds fee**)
- INITIAL PAYMENT:** I will pay my 1st month's premium, admin fee, association dues and one time enrollment fee **via check/money order**. My check/money order is enclosed with the Enrollment Form.
- MONTHLY PAYMENT:** Send me a monthly invoice to pay my monthly premium, admin fee and association dues. I agree to pay an **additional fee of \$10** to receive a monthly invoice.
- ELECTRONIC FUNDS TRANSFER (**Fill out EFT Authorization Form below and include a legible voided check.**)
- INITIAL PAYMENT:** EFT my bank account for 1st month's premium, admin fee, association dues and one time enrollment fee. EFT occurs between the 15th and 20th of the month prior to the effective date.
- MONTHLY PAYMENT:** EFT my bank account for the monthly premium, admin fee and association dues. EFT occurs between the 15th and 20th of the month prior to the next months coverage.

I understand this authority is to remain in full force and in effect until IRG has received written notification from me of its termination in such time and such manner as to afford IRG and depositor a reasonable opportunity to act on it. I have the right to stop payment of a debit entry (deduction) by notification to IRG three business days or more before this payment is scheduled to be made. Please be aware that your bank statement will reflect the debit as IRG-HEALTH.

APPLICANT SIGNATURE (REQUIRED) <b>X</b>	PRINT NAME	DATE
ACCOUNT HOLDER SIGNATURE (REQUIRED if paying via EFT) <b>X</b>	PRINT NAME	DATE

**EFT AUTHORIZATION FORM — FORM MUST BE FILLED OUT IN BLACK BALLPOINT INK - PLEASE PRINT CLEARLY**

BANK NAME	BANK ROUTING NUMBER	BANK ACCOUNT NUMBER
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Voided check is **required** and must be legible. **No monthly charge for EFT.**

PLEASE ATTACH A CHECK MARKED

**VOID**

TO ENSURE ACCURACY