



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 EFT: Include a legible copy of a voided check
- Paying via Credit or Bank Card: Complete all card information on page 2
- Mail or Email Completed Application to:

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

mpw@cnyfinancialgroup.com



Enrollment Application

APPLICATION TYPE: OPEN ENROLLMENT ENROLLMENT CHANGE TERMINATION

LEVEL OF COVERAGE: SINGLE MEMBER & SPOUSE MEMBER & DEPENDENT(S) FAMILY

SELECT PLAN TYPE: SELECT ADVANCE PREMIUM

			REQUESTED EFFECTIVE DATE
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 (If different from 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	

Note: If you are applying for coverage for your spouse and/or children, please list each one below

LAST NAME	FIRST NAME	RELATIONSHIP	GENDER	SOCIAL SECURITY NUMBER	BIRTHDATE (MM/DD/YYYY)	CHECK IF OVER 19 OR DISABLED
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

INSURANCE COMPANY			
STREET ADDRESS		CITY	STATE
		ZIP CODE	
POLICY NUMBER		EFFECTIVE DATE (MM/DD/YYYY)	

I understand these medical plans are a low-cost alternative (limited medical), providing medical insurance at fixed amounts, and these limited benefits are paired with medical discount to designated providers. The Limited Benefit Medical Plan offered thru AIM is a group insurance program. The group insurance benefits vary depending on the plan selected. This insurance is not a basic or major medical coverage and is not designated as a substitute for basic health insurance or major medical coverage. The plan limitations are disclosed in the certificate of coverage provided in the fulfillment kit which will be mailed to the applicant on or about the effective date of coverage. I further understand that this policy has a preexisting conditions limitation. Preexisting conditions are not covered until the policy has been in effect for more than 12 months.

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 benefit plan I selected above. All applicants must sign below. Any false statement will be cause for immediate cancellation of coverage.

APPLICANT SIGNATURE	DATE
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REP NAME	REP SIGNATURE	DATE	TELEPHONE	REP CODE
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SELECT MONTHLY PREMIUM (CHECK APPROPRIATE BOX)

SELECT PLAN RATES

<input type="checkbox"/> SINGLE \$118.00	<input type="checkbox"/> MEMBER & SPOUSE \$198.00	<input type="checkbox"/> MEMBER & DEPENDENT(S) \$173.00	<input type="checkbox"/> FAMILY \$234.00
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ADVANCE PLAN RATES

<input type="checkbox"/> SINGLE \$161.00	<input type="checkbox"/> MEMBER & SPOUSE \$269.00	<input type="checkbox"/> MEMBER & DEPENDENT(S) \$247.00	<input type="checkbox"/> FAMILY \$344.00
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PREMIUM PLAN RATES

<input type="checkbox"/> SINGLE \$192.00	<input type="checkbox"/> MEMBER & SPOUSE \$331.00	<input type="checkbox"/> MEMBER & DEPENDENT(S) \$303.00	<input type="checkbox"/> FAMILY \$428.00
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Step 1. Enter Premium Selected Above:	\$ _____
Step 2. One Time Enrollment Fee:	\$ <u>85.00</u>
Step 3. Optional Emergency Accident Rider:	<u>Not Available in NY</u>
<input type="checkbox"/> Single - \$19.48 <input type="checkbox"/> EE & Spouse - \$19.48 <input type="checkbox"/> EE & Child(ren) - \$19.48 <input type="checkbox"/> Family - \$19.48	_____
Step 4. Optional Hospital Rider:	\$ _____
<input type="checkbox"/> Single - \$38.00 <input type="checkbox"/> EE & Spouse - \$58.00 <input type="checkbox"/> EE & Child(ren) - \$79.00 <input type="checkbox"/> Family - \$79.00	_____
Step 5. Critical Illness Rider:	\$ _____
<input type="checkbox"/> Single - \$24.00 <input type="checkbox"/> EE & Spouse - \$42.00 <input type="checkbox"/> EE & Child(ren) - \$42.00 <input type="checkbox"/> Family - \$42.00	_____
Step 6. Total Contribution at enrollment - Add Steps 1-5:	\$ _____

PAYMENT OPTIONS

(CHECK APPROPRIATE BOX)

ELECTRONIC FUNDS TRANSFER (Requires a legible copy of a voided check)

INITIAL PAYMENT: Please EFT my bank account for the first month's premium and one time enrollment fee.

This will occur anytime from the date of enrollment to 5 days after enrollment.

MONTHLY PAYMENT: Please EFT my bank account for the monthly premium. The charge is based on the effective date of your primary policy. This will normally occur between the 1st and 6th day of the month for coverage effective on the 15th of the month and between the 15th and 20th of the month prior for coverage beginning on the first of next month. (There is NO monthly charge for EFT)

CREDIT OR DEBIT CARD PAYMENT

INITIAL PAYMENT: Please charge my card for first month's premium, the 3% processing fee of the premium fee and one time enrollment fee. This will occur at the time your application is processed.

MONTHLY PAYMENT: Please charge my card for the monthly premium and processing fee of 3% of the premium fee. The charge is based on the effective date of your primary policy. This will normally occur between the 1st and 6th day of the month for coverage effective on the 15th of the month and between the 15th and 20th of the month prior for coverage beginning on the first of next month.

CC Type: _____ CC #: _____

Exp Date: _____ Verification Code: _____ (3 digit number on the back of the card)

I understand that this authority will remain in effect until the company has received written notification from me of its termination.		
APPLICANT SIGNATURE	PRINT NAME	DATE