

Vytra SmartStart Application Instructions

1. Print and complete application packet.
2. Sign and date applications.
3. Include most recent business tax returns.
Corporations will submit 1120S or NYS-45. A 1040 w/
Schedule C is required for self-employed individuals
plus a copy of business certificate.
4. Check for 1st month premium from business checking
account made out to: **Vytra**
5. Review application for accuracy, including your
preferred start date (either 1st or 15th of month).
6. Mail application to:

Life and Health Quote Corp.
Vytra SmartStart
328 Hillside Ave.
Williston Park, N.Y. 11596

If you require assistance, please call us at: **516-877-5099**

We will contact you upon receipt of your application.



SmartStart Membership Application

Vytra Health Services, Inc.

Subscriber Information									
Last Name	First Name	Middle Initial	Telephone No.	Home	Work	Fax No.			
Address (Street No.)		City	State	Zip Code	E-mail Address			<input type="checkbox"/> Male <input type="checkbox"/> Female	

While enrolled in Vytra, will you or any member of your family be covered by any other medical plan? Name of Contract Holder _____

Other Insurance (Name of Insurance) _____ Ins. ID# _____ None End Stage Renal Disease Yes
 Social Security Disability Medicare Part A ID# _____ Part B ID# _____ Individual Coverage Family Coverage

Enrollment Information									
Name <i>Indicate if Last Name is different</i>	Birth Date <i>Mo/Day/Yr</i>	Social Security No.	Sex	Full Time Student Over 19	Former Health Coverage <i>(Previous 12 months)</i>	Dates of Former Coverage <i>From To</i>	Primary Hospital Name <i>(See selections below)</i>	Hospital ID# <i>(See selections below)</i>	Disabled
Your Last Name First M.I.				<input type="checkbox"/> Y <input type="checkbox"/> N					<input type="checkbox"/> Y <input type="checkbox"/> N
Spouse				<input type="checkbox"/> Y <input type="checkbox"/> N					<input type="checkbox"/> Y <input type="checkbox"/> N
Dependent				<input type="checkbox"/> Y <input type="checkbox"/> N					<input type="checkbox"/> Y <input type="checkbox"/> N
Dependent				<input type="checkbox"/> Y <input type="checkbox"/> N					<input type="checkbox"/> Y <input type="checkbox"/> N
Dependent				<input type="checkbox"/> Y <input type="checkbox"/> N					<input type="checkbox"/> Y <input type="checkbox"/> N
Dependent				<input type="checkbox"/> Y <input type="checkbox"/> N					<input type="checkbox"/> Y <input type="checkbox"/> N

Hospital Name Hospital ID#	Hospital Name Hospital ID#	Hospital Name Hospital ID#	Hospital Name Hospital ID#
Brookhaven Memorial Hospital C006	New Island Hospital C019	South Nassau Communities Hospital C005	Good Samaritan Hospital C008
Good Samaritan Hospital C008	St. Catherine of Siena Hospital C84360	Winthrop University Hospital C001	Mercy Medical Center C021
Mercy Medical Center C021	St. Charles/J.T . Mather Hospitals C84467		

I decline dependent coverage for my spouse. I decline dependent coverage for my other dependents. Have you or any of your dependent(s) ever been a member of Vytra before? Yes No
 If yes, indicate the former employer and your name *(if different from shown)* _____

Employer Information <i>Please complete all shaded areas</i>						
Employer Name	Group No.	Date of Hire	Effective Date	Employer Waiting Period	Telephone No.	
Address	City	State	Zip Code	Check one: <input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire <input type="checkbox"/> Status Change <i>(see below)</i> <input type="checkbox"/> Conversion <i>(Direct Pay)</i>		

Enrollment	
<p><input type="checkbox"/> I hereby apply for enrollment in Vytra Health Services, Inc. which provides health insurance for myself and the eligible dependents listed above. The information provided is true and correct to the best of my knowledge. I understand that my coverage and benefits may be affected by failure to provide complete and accurate information.</p> <p>In the event that a premium contribution is required of me, I agree to pay, in advance the premium amounts applicable for the contract under which I am covered. I authorize the employer identified above to deduct from payroll such applicable premium amounts and to remit them to Vytra.</p> <p>I understand that coverage is not included for a pre-existing condition during a 12 month waiting period, or lesser period if eligible for credit for previous coverage. I understand and agree that my employer may discuss my health care coverage with Vytra and provide you with information regarding the coverage and benefits I had with them.</p> <p>I authorize all medical information relative to my care or that of any member of my family to be released to Vytra Health Plans for all purposes.</p> <p>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, and is subject to a civil penalty not to exceed the limits defined in the Insurance Law and the stated value of the claim for each such violation.</p>	<p>Status Change: <input type="checkbox"/> Add dependent <input type="checkbox"/> Remove dependent <input type="checkbox"/> Address Change <input type="checkbox"/> Name Change</p> <p>Reason: _____</p> <hr/> <div style="border: 1px solid black; padding: 5px;"> <p style="text-align: center; margin: 0;">For Vytra Use Only</p> <p style="margin: 5px 0;">Is applicant currently working at least 20 Hours/Week? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> </div>
Applicant Signature	Date
Employer Signature <i>(Employer must cosign)</i>	



Small Business Employer Group Health Benefits Application

Company Name: _____ Effective Date: _____

Address: _____ Billing Address: _____

(if different) _____

Type of Business: _____

Contact: _____ Title: _____

Phone: _____ Fax: _____

Email: _____

Present Health Insurance Carrier: _____ Dates of Coverage: From ___/___/___ To ___/___/___

Has your group insurance ever been cancelled for non-payment of premium? Yes No

If your answer is yes, please explain on a separate page.

Total number of employees: _____ (Include full and part-time)

• Number of employees working 20 hours per week or more: _____

• Please indicate the required time period of employment, if any, before an employee becomes eligible for health care coverage (*eligibility lag*): _____

Indicate how much you contribute toward employee coverage:

Single _____ Employee/Spouse _____ Employee/Child(ren) _____ Family _____

Agent/Broker of Record: (if applicable)

_____ <i>Name of Agent/Broker</i>
The agent/broker named above is hereby appointed as agent/broker in all dealings between Vytra Health Plans and _____ . This appointment will remain in effect until it is rescinded in writing by _____ <i>Company Name</i>
the undersigned.
Signature _____ <i>Signature of Owner, Partner or Officer</i>

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 all current employees eligible for health coverage have the option of joining Vytra now, or on my group's next annual anniversary date.**

Signature of Owner, Partner or Officer

Print Name

Title

Date



Premium Quote Sheet

Name of Company _____

Effective Date Requested _____

Plan Selected:

HMO Option # _____ Rating Structure Quoted Two Tier Three Tier Four Tier

POS Option # _____ 80th UCR 90th UCR Four Tier Rating

MaxAccess Option _____ Four Tier Rating SmartStart Three Tier Rating

Rx Plan None \$5/\$10/\$30 \$5/\$12/\$35 \$7/\$15/\$50 \$10/\$20/\$50 \$15/\$25/\$50
 Other _____

Except as noted below:

HMO Options Option A \$5/\$10/\$35 Rx incl. Option B \$7/\$15/\$35 Rx incl. Option D \$10/\$20/\$40 Rx incl.

POS Options Option B \$5/\$10/\$35 Rx incl. Option F \$7/\$15/\$35 Rx incl. Option M \$10/\$20/\$40 Rx incl.

Vision Buy-Up Option Yes No

Group Breakdown

Plan Type _____	No. of Insured _____	x (Premium Quoted + Vision)	=	Total
Single	_____	x(_____ + _____)	=	_____
Emp. + 1	_____	x(_____ + _____)	=	_____
Emp./Child(ren)	_____	x(_____ + _____)	=	_____
Family	_____	x(_____ + _____)	=	_____

Plan Type _____	No. of Insured _____	x (Premium Quoted + Vision)	Total Due =	Total
Single	_____	x(_____ + _____)	=	_____
Emp. + 1	_____	x(_____ + _____)	=	_____
Emp./Child(ren)	_____	x(_____ + _____)	=	_____
Family	_____	x(_____ + _____)	=	_____
			Total Due	_____

Grand Monthly Total

 Broker, Agent or Owner (Please print name)

 Date

 Managing Agent/
 Associate Managing Administrator