Fage Financial
fagefinancial.com • (845) 499-2255 • info@fagefinancial.com

Membership Requirements

1. All members must be employed a minimum of twenty **(20)** hours per week.
2. Employee occupation must be listed.
3. All Social Security numbers, dates of birth, and provider names and numbers must be completed.
4. All plans with a spouse and/or dependent(s) having a different last name than the member **MUST** submit a marriage and/or birth certificate for the appropriate dependent(s).

Enrollment — Complete These Forms

1. Enrollment Worksheet
2. Health & Welfare Fund Application
3. Membership Form
4. ACH Authorization Form

Payment Instructions

1. The plan requires a **$125.00 Annual Administration Fee**.
2. Contributions for the medical plans are made in advance of the coverage period for which you are paying and can be made on a quarterly basis by mail or by automatic bank debit. If paying quarterly, the first payment must be **three (3)** months' premium. Future quarterly payments are due on the 15th of the month prior to the beginning of the quarter for which you are paying. If paying by automatic checking, a void check must be attached to the ACH Authorization Form. Automatic debits will occur on the 15th of the month prior to the month of coverage.
3. If your coverage is terminated for any reason, and you wish to be reinstated, you will be subject to a **$75 reinstatement fee**.

> **NOTE:** All payments received after the due date are subject to a late fee (currently $35). Payments that are returned as a "chargeback/not authorized" will incur a $50 fee. All other returned payments are subject to a $35 fee.

All enrollment materials must be received no later than the 20th of the month prior to the requested start date.

website: www.anthem.com

Includes health & welfare fund contribution, union dues and association fees

EPO — Monthly Rate	Amount
Single	**$1,482.95**
Employee + 1 Child	**$2,589.70**
Employee + Spouse	**$2,965.90**
Family	**$3,928.25**

Rates effective through 06/30/2027. All other fees are subject to change.

**** ONE CHECK PAYABLE TO A.F.I. ****

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Please check one payment mode: ☐ Monthly Automatic Check **OR** ☐ Quarterly E-mail Invoice

Medical Plan: $ _____ X _____ = $ _____

Annual Administration Fee: **$125.00**

Total Contribution at Enrollment: $ _____

NOTE: Completed paperwork must be received no later than the 20th of the month prior. No cancellation requests will be honored once a month has started.

Member Name _____ Rep. Name _____

Member Signature _____ Rep. Signature _____

Date _____

*Please note that it will take approximately 10 to 14 **business** days, after your effective date, for you to receive your ID# and cards from the insurance carrier.*
Member's Initials _____

LAST NAME (PRINT)	FIRST NAME	SOCIAL SECURITY NO.
		___ – ___ – ____
HOME ADDRESS — NUMBER AND STREET		
CITY	STATE	ZIP CODE
DATE OF BIRTH Month ___ / Day ___ / Year _____	MARITAL STATUS (CHECK ONE) ☐ Married ☐ Single ☐ Widowed ☐ Separated/Divorced	DATE OF EMPLOYMENT Month ___ / Day ___ / Year _____
EMPLOYER'S NAME		HOURLY RATE
NAME OF BENEFICIARY		RELATIONSHIP

I hereby apply for Group Insurance for which I am or may become eligible.

Date _____ ✕ Signature of Applicant _____

Dependent Information

Names of Dependents	Social Security #	Spouse	Son	Daughter	Date of Birth

For Fund Use Only

Effective Date	Class	Termination	Reinstatement

Personal Health Questions for Applicant and Dependents — Circle YES or NO. Must answer ALL questions.

1. Heart attack, brain tumor, stroke, heart disease or heart problems? **YES NO**
2. Cancer, tumor, lymphoma or any type of transplant? **YES NO**
3. Any surgery or hospitalization in the last 5 years, OR currently pending, planned or recommended? **YES NO**
4. Emphysema or COPD? **YES NO**
5. Kidney failure, dialysis, or disorder of the liver, stomach, pancreas, colon or bladder? **YES NO**
6. Seizures, epilepsy, hemophilia, sleep apnea or blood disorder? **YES NO**
7. Diabetes, endocrine, autoimmune, Crohn's Disease or arthritis or pituitary disorder, growth disorder, lupus, MS, AIDS or HIV+? **YES NO**
8. Currently pregnant, premature delivery or multiple births? **YES NO**
9. Is anyone listed on the application taking or currently taking medications in the last 12 months? **YES NO**

If **Yes** answer to questions **#1–8**, please provide date, type and further treatment if any.

If **Yes** answer to question **#9**, list any and all **medications** taken in the last 12 months below by anyone listed on the application. Please list the name of medication, dosage and corresponding medical condition information. Please include diagnosis date and date of last physician visit for condition.

Applicant Signature _____ Date _____

700 Anthem EPO Plan

Membership Form

MEMBER INFORMATION

MEMBER LAST NAME	**MEMBER FIRST NAME**	
MEMBER SS#	**MEMBER DOB**	
HOME PHONE	**CELL PHONE**	
MEMBER GENDER ☐ Male ☐ Female	**EMAIL**	
MARITAL STATUS ☐ Single ☐ Married ☐ Domestic Partner		
STREET ADDRESS		**APT #**
CITY	**STATE**	**ZIP**
EMPLOYED 20+ HRS PER WEEK (ON AVERAGE) ☐ No ☐ Yes ☐ W2 ☐ K1 ☐ Schedule C	**OCCUPATION**	
BUSINESS NAME	**BUSINESS PHONE**	
BUSINESS ADDRESS	**BUSINESS EMAIL**	

SPOUSE / DOMESTIC PARTNER INFORMATION (if applicable)

SPOUSE/PARTNER LAST NAME (IF DIFFERENT)	**SPOUSE/PARTNER FIRST NAME**
SPOUSE/PARTNER SS#	**SPOUSE/PARTNER DOB**
SPOUSE/PARTNER GENDER ☐ Male ☐ Female	**SPOUSE/PARTNER EMAIL**

DEPENDENT INFORMATION (if applicable)

Last Name (if different)	First	Middle	DOB	Age	Relationship to Member	SS #

PLAN SELECTION

PLAN NAME	EFFECTIVE	PREVIOUS CARRIER
700 Anthem EPO Plan		

**** All documents included in my application for benefits have been completed accurately and truthfully to the best of my knowledge.*

Member Signature _____ **Date** _____

This bank account deduction program allows you to have your premium automatically deducted from your bank account. Please complete and sign this form to authorize withdrawals.

Member's Name: _____ _____

Last Name First Name

Payer's Name: *(if different from above)* _____

Address: _____

INITIAL WITHDRAWAL

Date: _____ Amount: $ _____

RECURRING WITHDRAWAL

Start Date: _____ Amount: $ _____

☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

Payer's Bank Name: _____

Routing Number: _____ **Account Number:** _____

I hereby authorize A.F.I. to initiate withdrawal(s) from my bank account in such amount as needed to keep my benefits active until revoked. Revocation must take the form of written notification from member and/or payer in such manner to afford a reasonable opportunity to act on it and/or within 30 days. I understand this payment plan may be cancelled at any time. I represent and warrant that I am authorized to execute this authorization agreement and I indemnify and hold A.F.I., bank and their agents harmless from damages, loss or claims resulting from all authorized actions hereunder.

****** Note: $35 return fee for "non sufficient funds"; $50 return fee for "non authorized or stopped, account frozen, etc"***

Payer's Signature: _____ **Date:** _____

Print Name: _____ ☐ New Participant ☐ Change

ATTACH VOIDED CHECK

I acknowledge that my enrollment materials were submitted after the 20th of the month prior to the effective date of coverage.

Therefore, as a result of the delay, I understand and accept that I may not be able to verify my eligibility sooner than 30 days from the start date of enrollment.

I further understand and accept that my identification card(s) may arrive no sooner than 30 days from the requested start date of enrollment.

I also understand and accept that I may have to contact the carrier directly regarding any out-of-pocket expenses and/or claims issues.

I understand that if I need additional assistance in expediting the process mentioned above, I can contact customer service at (914) 366-6868.

Signature of Member _____ Date _____