



# New York Business Group on Health, Inc.

## Membership Application & Questionnaire

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Membership is open to all employers, health insurance companies, providers of healthcare, consultants, government agencies and labor organizations in New York, New Jersey, and Connecticut. Non-resident membership is open to organizations which are outside the Tri-State Area.

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**Company/Organization:**

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Check One:     Corporate Headquarters     Other (describe):

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How did you hear about NYBGH?

- Conference Brochure
  - Monthly Breakfast Club
  - NYBGH Publication
  - NYBGH Member: \_\_\_\_\_
  - Other: \_\_\_\_\_
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***Primary Contact:*** Each member company should designate one individual as the primary NYBGH contact person. The responsibility of the primary contact is to be the liaison between the company and NYBGH. This involves disseminating NYBGH information to appropriate company personnel, to key officers and to those in the organization who are responsible for health-cost management. The primary contact may suggest topics for conferences and participate in one or more of the three NYBGH task forces: Elder Care, Mental Health, and the Health Benefits Advisory Group. This individual should provide comments and suggestions that will enhance the value of NYBGH activities. The primary contact will have an opportunity to name secondary contacts who are to receive NYBGH mailings.

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**Primary Contact's Name:**

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**Title:**

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**Address:**

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**City/State/Zip Code:**

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**Telephone:**

**Fax:**

**E-mail:**

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I would like to connect our organization's web site to NYBGH membership roster page:     yes     no

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**Web Site (if applicable):**

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**Please state briefly the business function of your company/organization:**

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**Dues Information:** Annual membership dues are based on the number of company employees in the Tri-State Area (NY, NJ, CT). Dues are payable January 1st for the calendar year. The dues schedule for member companies with special fiscal cycles should be discussed with Jennifer Cole, Coordinator, Membership Services at 212-252-7440 ext. 223. All checks should be made payable to: **NEW YORK BUSINESS GROUP ON HEALTH, INC.** Mailing address: *61 Broadway, Suite 2705, New York, NY 10006.*

**Number of Employees in the Company/Organization: Tri-State:** \_\_\_\_\_ **Nationally:** \_\_\_\_\_

**If your company/organization is a healthcare insurer, consultant, provider, or other healthcare related organization:**

| <u>Number of Employees</u>            | <u>Membership Dues</u> |
|---------------------------------------|------------------------|
| 1-24 (small broker firms/consultants) | \$550                  |
| 25-499                                | \$1100                 |
| 500+                                  | see scale below        |

**If your company/organization is not related to the healthcare industry:**

| <u>Number of Employees</u> | <u>Membership Dues</u> |
|----------------------------|------------------------|
| under 250                  | \$550                  |
| 250-499                    | \$1100                 |
| 500-999                    | \$2000                 |
| 1000-2999                  | \$3000                 |
| 3000-4999                  | \$3900                 |
| 5000-9999                  | \$4900                 |
| 10000-24999                | \$5900                 |
| 25000+                     | \$6800                 |

Calculated Dues: \$ \_\_\_\_\_ **Check Enclosed**  **Check being processed**

**Secondary Contacts:**

Name: \_\_\_\_\_  
 Title: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City/State/ZipCode: \_\_\_\_\_  
 Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 E-mail: \_\_\_\_\_

Name: \_\_\_\_\_  
 Title: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City/State/ZipCode: \_\_\_\_\_  
 Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 E-mail: \_\_\_\_\_

Name: \_\_\_\_\_  
 Title: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City/State/ZipCode: \_\_\_\_\_  
 Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 E-mail: \_\_\_\_\_

Name: \_\_\_\_\_  
 Title: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City/State/ZipCode: \_\_\_\_\_  
 Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 E-mail: \_\_\_\_\_

**Please Fax this form to NYBGH at (212) 252-7448.**

**Please indicate which healthcare issues are most important to you and your organization. Please rank these items with a number 1—5, “1” representing the most important topic.**

- Aging Workforce Issues       Eldercare/Caregiving Resources for Employees       Prescription Drugs  
 Consumer-Driven Health Benefits       Health Plan Evaluation/Quality       Provider Quality  
 Depression/Behavioral Health       Integrated Disability       Retiree Health Benefits  
 Disease/Care Management       Pay for Performance Programs       Plan Design Changes and Communication Strategies  
 Other: \_\_\_\_\_

**How do you classify your industry?**

- Communications       Financial/Legal Services       Manufacturing       Transportation/Utilities  
 Consulting       Government       Pharmaceutical       Wholesale/Retail  
 Education       Healthcare Insurer       Services  
 Entertainment       Healthcare Provider       Technology  
 Other: \_\_\_\_\_

**What type of healthcare benefit plans does your company offer for its employees?**

| Type of Plan     | Plan Offered (y/n) | Insurance Carrier | Percentage of Employees Enrolled | Self-Insured (y/n) | Fully-Insured (y/n) |
|------------------|--------------------|-------------------|----------------------------------|--------------------|---------------------|
| Traditional Plan |                    |                   |                                  |                    |                     |
| PPO              |                    |                   |                                  |                    |                     |
| HMO              |                    |                   |                                  |                    |                     |
| POS              |                    |                   |                                  |                    |                     |
| HSA              |                    |                   |                                  |                    |                     |
| HRA              |                    |                   |                                  |                    |                     |

Do you offer Long-Term Care insurance?  
 Yes       No

How does your company assess the quality of the health plans it provides?  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you "carve out" any portion of your health benefits?  
 Yes       No

- Which Ones?
- Dental
  - Pharmacy
  - Vision
  - Mental Health
  - Disease Management
  - Other: \_\_\_\_\_

Please enclose descriptive literature about your organization, if available.  
 Date: \_\_\_\_\_ Completed by: \_\_\_\_\_

*If you have any questions, please do not hesitate to contact Jennifer Cole: 212.252.7440 ext.223/ nybgh@nybgh.org.*