

MEMBERSHIP APPLICATION

All applications for membership and renewal of membership are subject to approval by the DVHCC Board of Directors and contingent upon receipt of a check for Seven Hundred Fifty (\$750.00) dollars representing the one-time initiation fee of Five Hundred (\$500.00) dollars and the first year's annual dues of Two Hundred Fifty (\$250.00) dollars. **Please make your check payable to the Delaware Valley Health Care Coalition, Inc.**

By completing this application, you hereby represent that you have the legal authority to bind your organization; and hereby agree as follows:

1. To adhere to the obligations of Members of the Delaware Valley Health Care Coalition, Inc. in conformance with the Articles of Incorporation, By-Laws, and their Amendments, as well as any and all Resolutions passed by the Board of Directors of the Coalition.
2. To pay all applicable utilization fees as determined by the Delaware Valley Health Care Coalition Board of Directors as set forth in all vendor contracts that our organization becomes signatory to and receives such benefits of while continuing to maintain membership in the Coalition.
3. Further, as a Member of this Coalition, our organization acknowledges and agrees that if our organization fails to maintain "good standing" membership in the Delaware Valley Health Care Coalition, Inc. and continues to receive any pricing, discounts, rebates and/or quality services set forth in any Umbrella contract and/or Member Agreement to which our organization is signatory, then the DVHCC has the right to charge our organization an "access fee" equivalent to the normal utilization fees owed under the vendor contract based upon our organizations' past year's utilization for so long as our organization continues to receive such Coalition-negotiated benefits.
4. Further, it is the understanding of our organization that the Coalition has the right and obligation to collect any access fee or utilization fees either directly from the Vendor or Member should the Vendor fail to properly collect the utilization fees and remit the same to the Delaware Valley Health Care Coalition.
5. As a Member of this Coalition, our organization acknowledges and agrees that in order to determine the vendor's compliance with the terms of the contract and affiliated Member Fund agreements, the Coalition has the authority to acquire from all vendors certain de-identified, summary information and reports, provided that the information is consistent and in compliance with the provisions of the "Privacy Rule" (set forth in 45 CFR Part 164) of HIPAA.

PLEASE COMPLETE FORM THOROUGHLY AND MAIL, FAX OR E-MAIL TO INFO@DVHCC.ORG

1. ORGANIZATION: _____

2. CONTACT PERSON: _____

a. **CONTACT PERSON'S TITLE:** _____

b. **Is Contact a Third-Party Administrator? Y / N**

If YES, Name of Firm: _____

3. ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

4. PHONE: _____ 5. CELL/ 2nd Phone: _____

6. FAX: _____ 7. E-MAIL: _____

8. EMPLOYEE IDENTIFICATION NUMBER: _____

9. **FUND PARTICIPANTS**

a. ACTIVE MEMBERS: _____ b. ACTIVE MEMBERS' DEPENDENTS: _____

c. RETIRED MEMBERS: _____ d. RETIRED MEMBERS' DEPENDENTS: _____

e. TOTAL # of PARTICIPANTS = _____

10. CONSULTANT/ACTUARY: _____

CONSULTANT/ACTUARIAL FIRM: _____

11. MEDICAL CARRIER: _____

a. INSURED or SELF-INSURED? _____ b. MEDICAL RENEWAL DATE: ___/___/___

c. STOP-LOSS PROVIDER: _____ d. STOP-LOSS RENEWAL DATE: ___/___/___

12. TYPICAL HOURLY WELFARE CONTRIBUTION RATE: _____

13. RETIREE MEDICAL CARRIER: _____

a. PRE-65: _____

b. INSURED or SELF-INSURED? _____

c. MEDICARE ELIGIBLE: _____

d. INSURED or SELF-INSURED? _____

13. PHARMACY BENEFIT MANAGER: _____

a. INSURED or SELF-INSURED? _____ b. PBM RENEWAL DATE: ___/___/___

c. RDS: _____ d. EGWP: _____

14. DENTAL CARRIER: _____

a. INSURED or SELF-INSURED? _____ b. DENTAL RENEWAL DATE: ___/___/___

15. LIFE INSURANCE CARRIER: _____

a. INSURED or SELF-INSURED? _____ b. LIFE RENEWAL DATE: ___/___/___

16. VISION CARRIER: _____

a. INSURED or SELF-INSURED? _____ b. VISION RENEWAL DATE: ___/___/___

17. FIDUCIARY INSURANCE CARRIER: _____

a. FIDUCIARY INSURANCE RENEWAL DATE: ___/___/___

18. FUTURE ISSUES YOU WOULD LIKE THE DVHCC TO ADDRESS:

