

Dear mediabistro.com users:

Following are the forms you need to apply for mediabistro.com's new insurance program. We're offering low rates on health insurance through IRBA, the Independent Retail Business Association.

To qualify, you must:

- be a full-time freelancer or other self-employed professional, documentation of self employment must be submitted with your application in the form of a Schedule C or an NYS-45.
- include your Tax Form 1040
- work at least 20 hours per week and earn at least the minimum wage
- work in the Five Boroughs of New York City
- be a member of mediabistro.com's AvantGuild (MEMBERSHIP FEE: \$49/year)
- be a member of IRBA (Independent Retail Business Association) (MEMBERSHIP FEE: \$25/year for mediabistro.com members)

In this packet, you should find:

- membership application for mediabistro.com's AvantGuild
- membership application for IRBA
- employer application (if self-employed, you can fill in your own name)
- enrollment application

Once you've selected a health insurance plan and completed ALL of the forms in this packet, mail your application, and proof of self employment as explained on the application, **PLUS** a check for the first month's premium charged by your selected plan, **PLUS** your \$49 AvantGuild membership fee, **PLUS** your \$25 IRBA membership Fee to:

IRBA-mediabistro
490 East 74th Street #5A
New York, NY 10021
Attention: Jason Silverman

That's it! If you've mailed your application and want to check on the status of your health insurance, get in touch with Jason by email at health@mediabistro.com

Thanks so much for joining mediabistro.com's AvantGuild! Please feel free to call us if you have any questions about mediabistro.com membership: 212-929-2588.

Sincerely,

Laurel Touby
Founder & Cyberhostess
mediabistro.com inc

mediabistro.com, in partnership with the Independent Retail Business Association, is offering freelancers and other self-employed individuals and their families affordable healthcare plans from HIP, GHI, Atlantis and Perfect Health three of New York's leading insurance carriers.

You can search their networks at HIPUSA.com, GHI.com and Atlantishp.com.

For more information visit <http://www.mediabistro.com/insurance/> or contact Jason Silverman at 212 879 0122.

Plan	Atlantis Plan One	Atlantis Split Copay Plan Two	Atlantis Split Copay Plan Three	Atlantis Plan Four	Atlantis Plan Low POS Five	Atlantis Plan Low HMO Six
Plan Type	POS	HMO (NEW PLAN!)	POS (NEW PLAN)	POS	POS	HMO
In Network						
Click Here To Search Atlantis Health Plans Provider Network						
Referrals Required?	No	No	No	No	No	No
Office Copay	\$20	\$25	\$25	\$20	\$20	\$20
Specialist Copay	\$20	\$40	\$40	\$20	\$20	\$20
Hospital Admission Copay	\$250	\$500	\$500	\$0	\$500	\$500
Prescription Copay	50%/50% ***See details in application form for explanation***	\$20 copay Generic, \$30 copay preferred-Brand name, \$40 non-preferred Brand name Rx's	\$20 copay Generic, \$30 copay preferred-Brand name, \$40 non-preferred Brand name Rx's	50%/50% ***See details in application form for explanation***	** mandatory generic Rx, \$10 generic, \$25 brand copay after \$250 deductible w/ \$500 annual max benefit for covered brand drugs **	** mandatory generic Rx, \$10 generic, \$25 brand copay after \$250 deductible w/ \$500 annual max benefit for covered brand drugs **
ER Copay	\$50	\$50	\$50	\$50	\$50	\$50
Out of Network						
Deductible	\$1000/\$2500	No coverage	\$2000/\$4000	\$2000/\$4000	\$2000/\$4000	No coverage
Coinsurance	70%		70%	70%	70%	
Out of Pocket Maximum	\$3000/\$6000		\$5000/\$10,000	\$5000/\$10,000	\$5000/\$10,000	
Additional Benefits						
Eyeglasses	None	None	None	None	None	None
Dental	None	None	None	None	None	None
DME	\$0 copay in net (ded & coins OON)	\$0 copay in net	\$0 copay in net (ded & coins OON)	\$0 copay in net (ded & coins OON)	\$0 copay in net (ded & coins OON)	\$0 copay in net (ded & coins OON)
Maximum Benefit	Unlimited in network (\$1mm OON)	Unlimited in network	Unlimited in network (\$1mm OON)	Unlimited in network (\$1mm OON)	Unlimited in network (\$1mm OON)	Unlimited in network
Monthly Rates - plans 1 - 4 renew August 1, 2007						
Single	\$378.70	\$269.05	\$289.38	\$364.33	\$260.49	\$248.67
Plus Spouse	\$757.40	\$538.10	\$578.76	\$728.66	\$520.98	\$497.34
Plus Child	\$757.40	\$538.10	\$578.76	\$728.66	\$520.98	\$497.34
	(1-child)	(1-child)	(1-child)	(1-child)	(1-child)	(1-child)
Family (Plus Spouse and Children)	\$1,095.69	\$778.44	\$837.26	\$1,054.12	\$753.68	\$719.48

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NEW HIP PLAN OPTIONS

Plan	HIP #1	HIP #2	HIP #3	HIP #4
Plan Type	HIP PRIME HMO 2006 PLAN #1	HIP PRIME HMO 2006 PLAN #2	HIP PRIME HMO 2006 PLAN #3	HIP SELECT PPO 2006 PLAN #4
In Network Benefits				
Referrals Required?	Yes	Yes	Yes	No
Office Copay	\$25	\$25	\$20	\$20
Specialist Copay	\$40	\$40	\$20	\$30
Deductible	None	None	None	\$1000 individual / \$2000 max per family
Coinsurance	None	None	None	90% of \$25,000
Hospital Admission Copay	\$500	\$500	\$500	deductible & coinsurance
Ambulatory Surgery	\$75	\$75	\$75	deductible & coinsurance
Prescription Copay	\$100 deductible; \$10 Generic copay; NO COVERAGE for Brand Name Rx's	\$50 annual deductible; \$20 generic, \$30 formulary brand name, \$50 non-formulary brand name Rx	\$100 deductible; \$10 Generic Copay, \$20 Formulary Brand Name, FORMULARY REQUIRED	\$50 annual deductible; \$20 generic, \$30 formulary brand name, \$50 non-formulary brand name Rx
ER Copay	\$100	\$100	\$50	\$50
Out of Network				
Deductible	No coverage	No coverage	No coverage	\$2,000 / \$4,000
Coinsurance				70% of 16,666
Out of Pocket Maximum				\$5,000 / \$10,000
Additional Benefits				
Eyeglasses	\$45 allowance every 24 months			\$0 copay/ \$25 for contacts every 12 months
Dental	Preventive Dental included			
Alternative Medicine	None			\$20 copay, 12 combined visits, nutrition, acupuncture, massage - 5 visit limit on massage
DME	Not Covered	\$50 deductible; appliances in full	\$50 deductible; appliances in full	\$50 deductible; appliances in full
Maximum Benefit	Unlimited			
Monthly Rates (effective 4/1/06 - 4/1/07)				
Single	\$363.60	\$391.05	\$424.12	\$348.51
Plus Spouse	\$711.14	\$766.02	\$832.17	\$681.06
Plus Child or Children	\$662.50	\$713.53	\$775.02	\$634.52
Family (Plus Spouse and Children)	\$1,079.27	\$1,163.22	\$1,264.36	\$1,033.22

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You can search their networks at HIPUSA.com, GHI.com and Atlantishp.com.

[For more information visit http://www.mediabistro.com/insurance/](http://www.mediabistro.com/insurance/) or contact Jason Silverman at 212 879 0122.

Plan	GHI PPO Plan One
Plan Type	PPO
In Network Benefits	
Click Here to Search GHI PPO network	
Referrals Required?	No
Office Copay	\$30
Specialist Copay	\$15
Hospital Admission Copay	\$500 Hospital Co-Payment
Ambulatory Surgery	None
Prescription Copay	<small> RX - Retail Pharmacy 30 day supply \$10 generic/50% preferred/50% non-preferred. \$100 deductible per person. \$300 family, \$3,000 annual maximum. Mail Order 90 day supply \$10 generic/50% preferred/50% non-preferred. Mandatory mail after initial fill and one refill. </small>
ER Copay	\$100
Out of Network	
Deductible	\$1000 deductible
Coinsurance	25% of \$10,000
Out of Pocket Maximum	\$3500 / \$10,500 combined deductible & coinsurance
Additional Benefits	
Eyeglasses	N / A
Dental	
DME	
Maximum Benefit	Unlimited
Monthly Rates (for plans effective 7/1/2006 - 9/1/2006)	
Single	\$577.06
Plus Spouse	\$1,471.50
Plus Child or Children	\$1,471.50
Family (Plus Spouse and Children)	\$1,471.50

Send your completed applications to:

**Jason Silverman
mediabistro-IRBA
490 East 74th Street, #5A
New York, NY 10021
Tel: 212 879 0122
Fax: 212 879 3557**

******* Please Note: Applications need to be received *****
***** 8 business days prior to the effective date *******

Make sure to include all of the following information:

- GHI Transaction Form for Small Groups -All questions answered, dated & signed in ink and must include employment date.
- IRBA Group Application for GHI EPO
- IRBA Membership Application
- Copy of current NYS-45, Schedule C, Form 1120, CT-4-S, Schedule F, Articles of Incorporation which must include letter from CPA.
- Business check for the total monthly premium payable to National Administrators Inc. (NAI)
- Check for \$49 for the annual Avant Guild membership fee payable to mediabistro.com.
- Copy of prior carrier bill
- Proof of full-time student status for all dependents at or exceeding the dependent age limit (19)

GHI Small Business Advantage Program Benefits Summary

Services	Maximum	In-network	Out-of-network
Hospital facility copayment per single hospital confinement		\$500	\$1,000
Hospital facility coinsurance			25%
Hospital facility coinsurance maximum (per calendar year)			\$5,000
Hospital facility allowance		GHI contracted rate	GHI's reasonable and customary charge
Medical copayment/coinsurance		\$30	25%
Medical allowance		GHI CBP fee schedule	GHI Medicare based fee schedule
Medical annual deductible (per calendar year)			\$1,000 per person/ \$3,000 per family
Medical coinsurance maximum (per calendar year)			\$10,000 per person/ \$30,000 per family
Annual maximum (combined medical/hospital per calendar year)			\$1,000,000
Lifetime maximum		None	None
Dependent children eligible until:	19, end of year		
Dependent student eligible until:	23, end of year		
Hospital inpatient services*: performed and billed by a hospital			
Acute care including: maternity and routine nursery care	365 days per single hospital confinement	Covered in full after \$500 copayment	25% coinsurance after \$1,000 copayment
Admissions for mental health and chemical dependency treatment		Not covered	Not covered
Medical rehabilitation		Not covered	Not covered
Outpatient services performed and billed by a hospital			
Pre-admission testing		Covered in full	25% coinsurance
Outpatient diagnostic laboratory		Covered in full after \$50 copayment	
Outpatient diagnostic radiology		Covered in full	
Outpatient dialysis		Covered in full	
Physical therapy	30 visits per person per calendar year	Covered in full	25% coinsurance
Chemotherapy		Covered in full	25% coinsurance
Radiation therapy		Covered in full	25% coinsurance
Outpatient/ambulatory surgery*		Covered in full after \$100 copayment	25% coinsurance after \$100 copayment
Other hospital-based services			
Skilled nursing facility care*	60 days per person per calendar year	Covered in full	25% coinsurance (copay waived)
Hospice care*— inpatient and outpatient	210 days per person per lifetime	Covered in full	Covered in-network only
Home health care services*	200 visits per person per calendar year	Covered in full	Covered in-network only
Medical services performed and billed by a provider other than a hospital			
Home and office visits, including outpatient clinic visits			
Chiropractic care			
Allergy care			
Physical therapy, osteopathic manipulation, occupational therapy	30 visits per person per calendar year	\$30 copayment	Covered in-network only
Speech therapy	10 visits per person per calendar year		
Diagnostic lab and radiology procedures			
Out-of-hospital specialists consultation			
Surgery out-of-hospital		Covered in full	25% coinsurance after deductible
Surgery in the hospital			
In-hospital medical care ¹		Covered in full	25% coinsurance after deductible
In-hospital consultations			
maternity services		Covered in full	25% coinsurance after deductible

¹Out of network providers (anesthesiologist, radiologist, pathologist and assistant surgeons) in a network Hospital is covered up to 100% of Ingenix/HIAA at the 80th percentile. Policy form number PLH-SGC-1003, PLH-SGC-1004, PLH-SGC-1005, et al.

GHI Small Business Advantage Program Benefits Summary

Services	Maximum	In-network	Out-of-network
Medical services performed and billed by a provider other than a hospital			
Home infusion therapy		Covered in full	Covered in-network only
Anesthesia		Covered in full	25% coinsurance after deductible ¹
Chemotherapy		Covered in full	Covered in-network only
Radiation therapy			
Wellness Care performed and billed by a provider other than a hospital			
Well baby and well child care up to age 19		Covered in full	25% coinsurance after deductible
Immunizations			
Preventive mammography and pap smear screening			
Preventive prostate screening			
Annual adult physical examination, including OB/GYN		\$30 copayment	Covered in-network only
Emergency care			
Emergency room facility charges		Covered in full after \$100 copayment	Covered up to hospital/facility allowed charge after \$100 copayment
Emergency room professional charges		Covered in full	Covered up to 100% of Ingenix/HIAA at the 80th percentile
Emergency ambulance (ground)		See out of network	GHI's reasonable and customary charge, subject to medical deductible and coinsurance
Emergency ambulance (air)		See out of network	Covered up to \$10,000 per occurrence
Emergency admission – facility charges	365 days per single hospital confinement	Covered in full	Covered up to the hospital/facility allowed charge
Emergency admission – professional charges		Covered in full	Covered up to 100% of Ingenix/HIAA at the 80th percentile
Inpatient mental health and chemical dependence treatment performed and billed by a facility*			
Mental health		Not covered	Not covered
Chemical dependence detox			
Chemical dependence rehabilitation			
Durable medical equipment			
Durable medical equipment services (Pre-certification required for items that cost \$2,000 or more)		Covered in full after \$100 deductible, \$1,500 annual maximum	Covered in-network only
Outpatient mental health and chemical dependence*			
Chemical dependence Treatment	60 visits per calendar, up to 20 visits for family therapy	\$30 copayment charge	25% coinsurance
Mental health treatment		Not covered	Not covered

*Precertification required

¹ Services received from out-of-network providers (anesthesiologist, radiologist, pathologist and assistant surgeons) in a network hospital are covered up to 100% of Ingenix/HIAA at the 80th percentile.

Retail Pharmacy Program 30 day supply (Covered in network only)	Mail Order Pharmacy Program 90 day supply (Covered in network only)
Generic/Preferred/Non-preferred	Generic/Preferred/Non-preferred
Member pays: \$10/50%/50%	Member pays: \$10/50%/50%
\$100 deductible per person, \$300 per family	Mandatory mail after initial fill and one refill
Annual maximum per person \$3,000	

This chart is not a complete benefit description or contract and should only be viewed as a summary to assist you in understanding this program. Coverage is subject to all terms, conditions, limitations and exclusions of the Certificate of Insurance. In the event of any inconsistency between this chart and the Certificate of Insurance of Insurance, the Certificate shall govern.

mediabistro.com/AvantGuild

MEMBERSHIP APPLICATION

SECTION I - GENERAL INFORMATION

Name of Business (or your name): _____

Your name: _____

Address: _____

Phone Number: _____

e-mail address: _____

Type of Business (i.e. graphic design, freelance writing, etc.): _____

Number of Full-time Employees including self (at least 20.0 hours/week): _____

Number of Part-time Employees including self (less than 20.0 hours/week): _____

SECTION II

I hereby apply for membership in mediabistro.com's AvantGuild. There is a \$49 annual membership fee. Please make check payable to mediabistro.com.

Date

Signature of Owner/Manager

Print Name

The information provided above is true and correct to the best of my knowledge. I understand that coverage and benefits may be effected by failure to provide complete and accurate information.

mediabistro.com c/o IRBA
Empire State Building • 350 5th Avenue • Suite 5220
New York, NY 10118
212 929-2588 • darby@mediabistro.com



INDEPENDENT & RETAIL BUSINESS ASSOCIATES, INC.
The Association for Independent Businesses

MEMBERSHIP APPLICATION

SECTION 1 - GENERAL INFORMATION

Name of Business: _____

Address: _____

Phone Number: _____

Owner/Manager: _____

Type of Business: _____

Number of Full-time Employees (at least 20.0 hours/week): _____

Number of Part-time Employees (less than 20.0 hours/week): _____

SECTION II - IRBA MEMBERSHIP FEES

Annual Membership dues per business of \$57.00 made payable to "IRBA."

SECTION III

I hereby apply for membership in the Independent and Retail Business Associates, Inc., "IRBA."

Date

Signature of Owner/Manager

Print Name

The information provided above is true and correct to the best of my knowledge. I understand that coverage and benefits may be effected by failure to provide complete and accurate information.

2003 Jericho Turnpike • New Hyde Park, NY 11040 • (516) 352-7000 • Fax (516) 352-3135
Empire State Building • 350 5th Avenue • Suite 5220 • New York, NY 10118 • (212) 947-2200 • Fax (212) 760-1049
1300 N. Congress Avenue • West Palm Beach, FL 33409 • (800) 228-PLAN • (561) 686-0048 • Fax (561) 686-3404
IRBA Headquarters • 4 Airline Drive • Suite 202 • Albany, NY 12205 • (518) 869-3618 • Fax (518) 869-3648 • Toll Free (800) 288-4722



INDEPENDENT & RETAIL BUSINESS ASSOCIATES, INC.

GROUP APPLICATION for GHI EPO

Company Name: _____

Address: _____

Company Phone # _____ Type of Business _____

Contact: _____ Title: _____

Total Number of Employees: _____

Total Number of EE's Working 20 hours or more per week: _____

Total number of eligible employees: _____

Total number of subscribers enrolling: _____

Single: _____ Employee/Spouse: _____ Employee/Child: _____ Family: _____

Present Insurance Carrier: _____

Dates of Coverage: From: _____ / _____ / _____ to _____ / _____ / _____

Requested Effective Date: _____

GUIDELINES FOR ALL PLANS

1. The employer must be a member in good standing of IRBA
2. All payments are to be made to National Administrators, Inc. (NAI) as administrators of IRBA. All applications that you submit must be accompanied with proof of business (ex: Schedule C, NYS-45, Certificate of Business, Etc.)
3. All member groups must be self employed or have employer/employee relationships
4. We cannot accept enrollments if they are not properly completed, and accompanied by premium payment.
5. Enrollments, changes and cancellations must be in the administrators office at least 20 days prior to effective date. See Submission Guidelines for exact date.
6. Your premium must be received before the 1st of the month of coverage to avoid termination of coverage.
7. The rates do not include a \$10 monthly billing fee. Billing fee will appear on first invoice and all subsequent invoices.

GHI EPO

Plan Applied For (check ONE plan)

Plan 1 - \$15 Office visit copay, Hospital covered in full, RX-\$10/25/40 voluntary mail order _____

Plan 2 - \$20 Office visit copay, Hospital covered in full, RX- \$10/25/40 voluntary mail order _____

Plan 3 - \$30 Office visit copay, \$500 Hospital copay, RX-\$10/25/40 voluntary mail order _____

Plan 4 - \$30 Office visit copay, \$1,000 Hospital copay, RX- \$10/25/40 voluntary mail order _____

Plan 5 - \$30 Office visit copay, \$500 Hospital copay, RX-\$50 retail ded, \$10/25/40, \$1,000 Retail Max, \$20/\$50/\$80 mail order copay, unlimited mail order maximum _____

Plan 6 - \$30 Office visit copay, \$1,000 Hospital copay, RX-\$50 retail ded, \$10/25/40, \$1,000 Retail Max, \$20/\$50/\$80 mail order copay, unlimited mail order maximum _____

The information provided above is true and correct to the best of my knowledge. I understand that coverage and benefits may be effected by failure to provide complete and accurate information.

Signature of Owner/Partner

Representative (PLEASE PRINT!)

Date

Representative's Phone Number

LETTER of CERTIFICATION

Please check or respond where appropriate (type or print):

I am a duly licensed:

A Certified Public Account (CPA), or

An Attorney,

Name:

Firm Name:

Firm Address:

Telephone Number:

State of

Licensure: _____

This letter of attestation is being provided on behalf of the following business entity:

Group's Name:

Group's Address:

Group's Telephone Number: _____ Groups TIN: _____

Group Officer's Name (from whom you received the written documentation reviewed in connection with this letter of attestation):

The principal place of business for this group is in New York and this business form is a:

(Check one box)

Sole Proprietorship, and the proprietor works a minimum of 20 hours per week.

Partnership

Corporation

Limited Liability Company (LLC)

Trust (attach supporting documentation)

Other Type of Business Entity

(explain) _____

(Please attach copies of supporting documentation.)

Check Applicable Box (es)

The following new employee

began working for this company on _____, and is working full-time (20 hours or more per week), and will be shown on future tax documents which can be reviewed at a later date.

This group is a new business, which started on _____ and will be filing tax documents, which can be reviewed at a future date.

I hereby certify that the information I have stated above is true based upon my review of books, records or other written documentation provided to me by the group, and that the materials I have attached to this letter in support of this certification are true and accurate copies of records of the group. This certification forms part of the group's application for insurance. New York Insurance Law provides that any person who knowingly and with the intent to defraud provides false or misleading statements of material facts, or conceals material information in order to obtain insurance, commits a fraudulent insurance act, which is a crime.

Signature: _____

Print Name & Title _____

Date:
