

Application for Member Organizations



ORGANIZATION NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE (AREA CODE/NUMBER) _____ FAX (AREA CODE/NUMBER) _____

E-MAIL (AHIP INTERNAL USE ONLY) _____ WEBSITE _____

MAILING ADDRESS (IF DIFFERENT) _____

CITY _____ STATE _____ ZIP _____

Organization - Products Offered (Check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Dental | <input type="checkbox"/> HMO | <input type="checkbox"/> Stop Loss |
| <input type="checkbox"/> Disability Insurance | <input type="checkbox"/> Individual Medical | <input type="checkbox"/> Supplemental Insurance |
| <input type="checkbox"/> Disease Management | <input type="checkbox"/> Long-term Care Insurance | <input type="checkbox"/> Third Party Administrator (TPA) |
| <input type="checkbox"/> Exchanges – Federal/State | <input type="checkbox"/> Medicare Supplement | <input type="checkbox"/> Utilization Review Organization (URO) |
| <input type="checkbox"/> Group Medical | <input type="checkbox"/> PPO | <input type="checkbox"/> Vision |
| <input type="checkbox"/> HDHP/HSAs | <input type="checkbox"/> Reinsurance | |

Participation in Government Programs

- | | | |
|---|---|--|
| <input type="checkbox"/> CHIP | <input type="checkbox"/> Medicaid Health Plan | <input type="checkbox"/> Medicare Part D |
| <input type="checkbox"/> CMS Dual Eligibles | <input type="checkbox"/> Medicare ACO | <input type="checkbox"/> PACE Plan |
| <input type="checkbox"/> Demonstration | <input type="checkbox"/> Medicare Advantage | <input type="checkbox"/> TRICARE |
| <input type="checkbox"/> FEHBP | <input type="checkbox"/> Medicare Cost Contract | |

Tax Status: ☐ For Profit ☐ Non-profit

Premium and Revenue

- Total Accident & Health Premium as of December 31st of the prior year: _____
- For TPAs, PPO Networks, and Disease Management Organizations, please provide gross revenues as of December 31st of the prior year: _____

Covered Lives (If applicable)

- | | | |
|--|--|------------------------|
| • Commercial Major Medical (Individual & Group): _____ | • Medicare Cost: _____ | • Medicaid/CHIP: _____ |
| • Medicare Advantage: _____ | • Medicare Part D (stand-alone): _____ | • Exchange: _____ |
| | | • ASO: _____ |

Ownership

- Is your organization owned (e.g., through majority stock ownership) or controlled (e.g., by majority representation on your Board of Directors) by another organization? ☐ Yes ☐ No
- If yes, please name the organization and explain the relationship to your organization: _____

Please List the States in Which Your Organization Does Business: _____

Application for Member Organizations

Executive/Senior Management Team:

Chief Executive

NAME _____

TITLE _____

PHONE (AREA CODE/NUMBER) _____ FAX (AREA CODE/NUMBER) _____

E-MAIL (AHIP INTERNAL USE ONLY) _____

Assistant to Chief Executive

NAME _____

TITLE _____

PHONE (AREA CODE/NUMBER) _____ FAX (AREA CODE/NUMBER) _____

E-MAIL (AHIP INTERNAL USE ONLY) _____

Finance/CFO

NAME _____

TITLE _____

PHONE (AREA CODE/NUMBER) _____ FAX (AREA CODE/NUMBER) _____

E-MAIL (AHIP INTERNAL USE ONLY) _____

Operations/COO

NAME _____

TITLE _____

PHONE (AREA CODE/NUMBER) _____ FAX (AREA CODE/NUMBER) _____

E-MAIL (AHIP INTERNAL USE ONLY) _____

Medical Director/Chief Medical Officer

NAME _____

TITLE _____

PHONE (AREA CODE/NUMBER) _____ FAX (AREA CODE/NUMBER) _____

E-MAIL (AHIP INTERNAL USE ONLY) _____

IT/Chief Information Officer

NAME _____

TITLE _____

PHONE (AREA CODE/NUMBER) _____ FAX (AREA CODE/NUMBER) _____

E-MAIL (AHIP INTERNAL USE ONLY) _____

Chief Analytics Officer

NAME _____

TITLE _____

PHONE (AREA CODE/NUMBER) _____ FAX (AREA CODE/NUMBER) _____

E-MAIL (AHIP INTERNAL USE ONLY) _____

Communications/Public Relations

NAME _____

TITLE _____

PHONE (AREA CODE/NUMBER) _____ FAX (AREA CODE/NUMBER) _____

E-MAIL (AHIP INTERNAL USE ONLY) _____

Legal Affairs/General Counsel

NAME _____

TITLE _____

PHONE (AREA CODE/NUMBER) _____ FAX (AREA CODE/NUMBER) _____

E-MAIL (AHIP INTERNAL USE ONLY) _____

Chief Marketing Officer

NAME _____

TITLE _____

PHONE (AREA CODE/NUMBER) _____ FAX (AREA CODE/NUMBER) _____

E-MAIL (AHIP INTERNAL USE ONLY) _____

Human Resources Officer

NAME _____

TITLE _____

PHONE (AREA CODE/NUMBER) _____ FAX (AREA CODE/NUMBER) _____

E-MAIL (AHIP INTERNAL USE ONLY) _____

Application for Member Organizations

Product Contacts:

Dental

NAME _____

TITLE _____

PHONE (AREA CODE/NUMBER) _____ FAX (AREA CODE/NUMBER) _____

E-MAIL (AHIP INTERNAL USE ONLY) _____

Disability Income

NAME _____

TITLE _____

PHONE (AREA CODE/NUMBER) _____ FAX (AREA CODE/NUMBER) _____

E-MAIL (AHIP INTERNAL USE ONLY) _____

Exchange

NAME _____

TITLE _____

PHONE (AREA CODE/NUMBER) _____ FAX (AREA CODE/NUMBER) _____

E-MAIL (AHIP INTERNAL USE ONLY) _____

FEHBP

NAME _____

TITLE _____

PHONE (AREA CODE/NUMBER) _____ FAX (AREA CODE/NUMBER) _____

E-MAIL (AHIP INTERNAL USE ONLY) _____

Individual Medical

NAME _____

TITLE _____

PHONE (AREA CODE/NUMBER) _____ FAX (AREA CODE/NUMBER) _____

E-MAIL (AHIP INTERNAL USE ONLY) _____

Long-term Care

NAME _____

TITLE _____

PHONE (AREA CODE/NUMBER) _____ FAX (AREA CODE/NUMBER) _____

E-MAIL (AHIP INTERNAL USE ONLY) _____

Medicaid

NAME _____

TITLE _____

PHONE (AREA CODE/NUMBER) _____ FAX (AREA CODE/NUMBER) _____

E-MAIL (AHIP INTERNAL USE ONLY) _____

Medicare

NAME _____

TITLE _____

PHONE (AREA CODE/NUMBER) _____ FAX (AREA CODE/NUMBER) _____

E-MAIL (AHIP INTERNAL USE ONLY) _____

Medigap

NAME _____

TITLE _____

PHONE (AREA CODE/NUMBER) _____ FAX (AREA CODE/NUMBER) _____

E-MAIL (AHIP INTERNAL USE ONLY) _____

Reinsurance

NAME _____

TITLE _____

PHONE (AREA CODE/NUMBER) _____ FAX (AREA CODE/NUMBER) _____

E-MAIL (AHIP INTERNAL USE ONLY) _____

Supplemental Insurance

NAME _____

TITLE _____

PHONE (AREA CODE/NUMBER) _____ FAX (AREA CODE/NUMBER) _____

E-MAIL (AHIP INTERNAL USE ONLY) _____

Application for Member Organizations

Additional Key Contacts:

Government Affairs – Federal Issues

NAME _____

TITLE _____

PHONE (AREA CODE/NUMBER) _____ FAX (AREA CODE/NUMBER) _____

E-MAIL (AHIP INTERNAL USE ONLY) _____

Government Affairs – State Issues

NAME _____

TITLE _____

PHONE (AREA CODE/NUMBER) _____ FAX (AREA CODE/NUMBER) _____

E-MAIL (AHIP INTERNAL USE ONLY) _____

Government Affairs – Grassroots

NAME _____

TITLE _____

PHONE (AREA CODE/NUMBER) _____ FAX (AREA CODE/NUMBER) _____

E-MAIL (AHIP INTERNAL USE ONLY) _____

Actuarial

NAME _____

TITLE _____

PHONE (AREA CODE/NUMBER) _____ FAX (AREA CODE/NUMBER) _____

E-MAIL (AHIP INTERNAL USE ONLY) _____

AHIP Survey Contact

NAME _____

TITLE _____

PHONE (AREA CODE/NUMBER) _____ FAX (AREA CODE/NUMBER) _____

E-MAIL (AHIP INTERNAL USE ONLY) _____

Claims

NAME _____

TITLE _____

PHONE (AREA CODE/NUMBER) _____ FAX (AREA CODE/NUMBER) _____

E-MAIL (AHIP INTERNAL USE ONLY) _____

Compliance

NAME _____

TITLE _____

PHONE (AREA CODE/NUMBER) _____ FAX (AREA CODE/NUMBER) _____

E-MAIL (AHIP INTERNAL USE ONLY) _____

Corporate Governance

NAME _____

TITLE _____

PHONE (AREA CODE/NUMBER) _____ FAX (AREA CODE/NUMBER) _____

E-MAIL (AHIP INTERNAL USE ONLY) _____

Customer Service

NAME _____

TITLE _____

PHONE (AREA CODE/NUMBER) _____ FAX (AREA CODE/NUMBER) _____

E-MAIL (AHIP INTERNAL USE ONLY) _____

Emergency Preparedness/Business Continuity

NAME _____

TITLE _____

PHONE (AREA CODE/NUMBER) _____ FAX (AREA CODE/NUMBER) _____

E-MAIL (AHIP INTERNAL USE ONLY) _____

Fraud

NAME _____

TITLE _____

PHONE (AREA CODE/NUMBER) _____ FAX (AREA CODE/NUMBER) _____

E-MAIL (AHIP INTERNAL USE ONLY) _____

Health & Wellness

NAME _____

TITLE _____

PHONE (AREA CODE/NUMBER) _____ FAX (AREA CODE/NUMBER) _____

E-MAIL (AHIP INTERNAL USE ONLY) _____

Application for Member Organizations

Additional Key Contacts Continued:

Pharmacy

NAME _____

TITLE _____

PHONE (AREA CODE/NUMBER) _____ FAX (AREA CODE/NUMBER) _____

E-MAIL (AHIP INTERNAL USE ONLY) _____

Privacy/HIPAA

NAME _____

TITLE _____

PHONE (AREA CODE/NUMBER) _____ FAX (AREA CODE/NUMBER) _____

E-MAIL (AHIP INTERNAL USE ONLY) _____

Tax

NAME _____

TITLE _____

PHONE (AREA CODE/NUMBER) _____ FAX (AREA CODE/NUMBER) _____

E-MAIL (AHIP INTERNAL USE ONLY) _____

Training & Learning Development

NAME _____

TITLE _____

PHONE (AREA CODE/NUMBER) _____ FAX (AREA CODE/NUMBER) _____

E-MAIL (AHIP INTERNAL USE ONLY) _____

In Submitting this Member Organization Application, the Applicant Agrees to the Following:

- If admitted to membership, to pay annual dues as determined by the AHIP Board of Directors.
- On behalf of the applicant, the undersigned agrees to the foregoing conditions and certifies that the information in this application is true and correct.

SIGNATURE _____ DATE _____

NAME _____ TITLE _____

Please mail or e-mail to:

AHIP, Membership Department, 601 Pennsylvania Ave., NW, South Building, Suite Five Hundred, Washington, DC 20004

E-mail: MembershipFrontline@ahip.org | Phone: 202.778.8502