LVBCH℠

Employers for Healthcare Value Since 1980

Membership Application Form For Employers

LVBCH Employer Application Form – To join the Lehigh Valley Business Coalition on Healthcare (LVBCH) as an employer member whose employees will be eligible to enroll in LVBCH programs (i.e., medical, dental, vision, Rx drug, etc.), please complete the following information about your organization. Fax the completed application form to 610-317-0142 or scan it and send it via email to LVBCH@LVBCH.com. Upon receipt of your application, we will send you an invoice for your annual dues. If you have questions, please contact us. **Please complete all fields on this application.**

1) Applicant's Business Name: _____
   a. Is this Business a subsidiary of another corporation? ☐**Yes** ☐**No**
   b. If Yes, enter the name of the Parent Corporation: _____
   c. If Yes, do you want to join without your Parent Corporation becoming a member: ☐**Yes** ☐**No**
2) Applicant's Business Billing Address: _____
3) Applicant's Business Website Address: _____
4) Description of Applicant's Primary Business: _____
5) Primary Contact Representative Name & Contact Information:
   a. Contact Name: _____
   b. Contact Title: _____
   c. Contact Email: _____
   d. Contact Phone: _____ Contact Fax: _____
   e. Mailing Address: _____
6) Number of regular full-time employees at the end of the applicant's immediately preceding fiscal year:
   a. _____ Number (#) of employees who work in PA
   b. _____ # of employees who do **NOT** work in PA but who **will** be enrolled in an LVBCH program
   c. _____ Total # of employees

7) Please answer the following Yes/No questions about your business:
   a. ☐**Yes** ☐**No** Is your business headquartered in PA?
   b. ☐**Yes** ☐**No** Is your business non-profit or tax-supported (i.e., school, municipality, college, etc.)?
   c. ☐**Yes** ☐**No** Is your business a healthcare provider, pharmaceutical, broker or insurance company?
   d. ☐**Yes** ☐**No** Is your business self-insured for medical coverage?

8) Please provide the following Benefits-related information about your "***Active***" employee population:
   a. Company Name of **Broker/Consultant**: _____
   b. Company Providing **Medical** Benefits: _____
   c. Company Providing **Dental** Benefits: _____
   d. Company Providing **Vision** Benefits: _____
   e. Company Providing **Rx Drug** Benefits: _____

The undersigned hereby applies for membership in LVBCH on behalf of the Business listed above.
If approved for membership, we hereby accept and agree to abide by the Articles of Incorporation, Bylaws and policies of LVBCH as now in effect or hereafter amended.

Signature: _____ **Date**: _____

Print Name: _____ **Print Title**: _____