Enrollment/Change Form

Empire BlueCross

Thank you for choosing Empire. So that we may quickly and accurately process your enrollment, please complete in full and sign in Section 7.

SECTION 1: REASON FOR ENROLLMENT/CHANGE – Please complete section A, B or C

A. NEW ENROLLMENT/ADDITION – Choose only one reason in bold

☐ **New hire** Applicants in companies with 50 or fewer employees must submit NYS-45, payroll records or W-4 forms to establish employment.

Date of change (MMDDYY)

☐ **Open enrollment**

☐ **Status change** - Select only one

☐ Marriage ☐ Newborn ☐ Adoption ☐ Retirement ☐ Medicare eligible

For ***Medicare eligible*** only, answer the following questions:

Eligibility criteria - Select only one ..... ☐ Age 65+ ☐ Disability ☐ End stage renal disease

Active employee? ..... ☐ Yes ☐ No

Electing company coverage as primary coverage? ..... ☐ Yes ☐ No

Electing Medicare-related coverage as primary coverage? ... ☐ Yes ☐ No

(If company size is under 20 employees and end stage renal disease does not apply, you must choose this option)

☐ **Right of Election for adult dependents eligible for coverage to age 30 under NYS law**

☐ **Mandatory Right of Election - NYS Qualified dependents only**

☐ **COBRA/NYS Continuation of coverage** Nature of COBRA/NYS event

☐ **Other**

B. CHANGE – Check all that apply. For all checked boxes below, please supply new information in Sections 3 and 4.

☐ Name ☐ Address ☐ Primary Care Physician (PCP) (HMO/Direct HMO/Direct POS/Empire POS plans only) ☐ Managed Dental Primary Care Dentist (PCD) (If your company offers an Empire Dental plan)

Date of change (MMDDYY)

C. CANCEL COVERAGE – Select only one

Note: If you are canceling your own coverage, please have your employer fill out an Employee Termination Form. For other cancellations, please check the appropriate box below and enter the name in the Applicant and Family portion in Section 4.

Spouse/Dependent ☐ Death ☐ Divorce ☐ Dependent no longer eligible ☐ Other

Date of event (MMDDYY)

SECTION 2: BENEFITS SELECTION

Medical Insurance [1] Select only one plan type:

	Large group plans only	Small group plans only
☐ Direct HMO	☐ EPO ☐ PPO	☐ Value EPO ☐ Empire PPO Plus
☐ HMO	☐ DPOS ☐ DSPOS	☐ Empire POS ☐ Empire EPO Stepped
☐ Empire Total Blue℠ Choice (HSA)	☐ Empire Total Blue℠ Choice (HRA)	☐ Empire PPO ☐ Empire EPO Essential
☐ Empire Prism℠ EPO	☐ Empire Prism℠ PPO	☐ Healthy New York

Indemnity ☐ Hospital/Medical or ☐ Hospital Only ☐ Other

Select only one coverage type: ☐ Individual ☐ Employee/Spouse ☐ Parent/Child(ren) ☐ Family

Dental Insurance [2] ☐ PPO Dental ☐ Managed Dental ☐ Voluntary Dental ☐ Other dental

Select only one coverage type: ☐ Individual ☐ Employee/Spouse ☐ Parent/Child(ren) ☐ Family

Vision Insurance [3] **Blue View Vision℠** Select only one coverage type: ☐ Individual ☐ Employee/Spouse ☐ Parent/Child(ren) ☐ Family

[1] Empire will facilitate the opening of a Health Savings Account in your name, as directed by your Employer. [2] If your company offers an Empire Dental Plan. [3] If your company offers a Blue View Vision plan.

SECTION 3: APPLICANT INFORMATION

Last name	First name	M.I.	Social Security no.

Sex ☐ M ☐ F	Birthdate (MMDDYY)	Marital status ☐ Single ☐ Married ☐ Domestic Partner (DP)	Marriage date (MMDDYY)	Enter state and country where married [4] →	State	Country

Street address	Apt. no.	Home phone no.

City	State	ZIP code	Daytime phone no.

Occupation	Primary language

E-mail address (requested for ages 18 and over)	☐ Yes, information may be sent to me electronically.	If you, your spouse, and/or dependents are Medicare eligible, please complete section 6.

[4] Marriage must have been entered into in a jurisdiction that recognizes its validity.

SECTION 4: APPLICANT AND FAMILY INFORMATION – Please list yourself and all eligible family members to be enrolled. Attach additional sheets if necessary.

Note: If you've chosen HMO/Direct HMO/Direct POS/Empire POS/DirectShare POS, please provide a primary care physician (PCP) for yourself and for each dependent. Please note that no out-of-network benefits are available to HMO/Direct HMO members except for emergency care. If you've chosen Managed Dental, please provide one Primary Care Dentist (PCD) for you and your dependents.

APPLICANT

Primary care physician (PCP) last name	Primary care physician (PCP) first name	PCP no.	Current patient of PCP? ☐ Yes ☐ No
Primary care dentist (PCD) last name	Primary care dentist (PCD) first name	PCD no.	Current patient of PCD? ☐ Yes ☐ No

☐ **SPOUSE** ☐ **DOMESTIC PARTNER**

Last name	First name	M.I.	Social Security no.

Sex ☐ M ☐ F	Birthdate (MMDDYY)	Primary language, if different

PCP last name	PCP first name	PCP no.	Current patient of PCP? ☐ Yes ☐ No

E-mail address (requested for ages 18 and over)	☐ Yes, information may be sent to me electronically.

DEPENDENT 1

Last name	First name	M.I.	Social Security no.

Sex ☐ M ☐ F	Married? ☐ Yes ☐ No	Birthdate (MMDDYY)	Primary language, if different

PCP last name	PCP first name	PCP no.	Current patient of PCP? ☐ Yes ☐ No

E-mail address (requested for ages 18 and over)	☐ Yes, information may be sent to me electronically.

Relationship: ☐ Child ☐ Full-time student[5] ☐ Disabled child[6] ☐ Make available age 29 adult dependent child

DEPENDENT 2

Last name	First name	M.I.	Social Security no.

Sex ☐ M ☐ F	Married? ☐ Yes ☐ No	Birthdate (MMDDYY)	Primary language, if different

PCP last name	PCP first name	PCP no.	Current patient of PCP? ☐ Yes ☐ No

E-mail address (requested for ages 18 and over)	☐ Yes, information may be sent to me electronically.

Relationship: ☐ Child ☐ Full-time student[5] ☐ Disabled child[6] ☐ Make available age 29 adult dependent child

DEPENDENT 3

Last name	First name	M.I.	Social Security no.

Sex ☐ M ☐ F	Married? ☐ Yes ☐ No	Birthdate (MMDDYY)	Primary language, if different

PCP last name	PCP first name	PCP no.	Current patient of PCP? ☐ Yes ☐ No

E-mail address (requested for ages 18 and over)	☐ Yes, information may be sent to me electronically.

Relationship: ☐ Child ☐ Full-time student[5] ☐ Disabled child[6] ☐ Make available age 29 adult dependent child

[5] Child must exceed contractual dependent age and attend accredited college or university. Submit proof with this form. Proof is required annually.
[6] Please submit Request for Disabled Child form (HAC506) with this form; child age must exceed contractual dependent age.

SECTION 5: OTHER COVERAGE INFORMATION – This section must be completed

Do you, or your family members, currently have, or have had, health insurance in the past 11 months?
☐ Yes ☐ No **If yes, please complete the following:**

Name(s) of person(s) (first, M.I., last)	Insurance company information	Date coverage	Provided by employer?	Employment status	Contract type
Self	Name Phone Certificate (policy no.)	Began Ended	☐ Yes ☐ No	☐ Active ☐ Retiree	☐ Individual ☐ Family ☐ Employee/Spouse ☐ Parent/Child(ren)
☐ Spouse ☐ Domestic Partner	Name Phone Certificate (policy no.)	Began Ended	☐ Yes ☐ No	☐ Active ☐ Retiree	☐ Individual ☐ Family ☐ Employee/Spouse ☐ Parent/Child(ren)
Dependent 1	Name Phone Certificate (policy no.)	Began Ended	☐ Yes ☐ No	☐ Active ☐ Retiree	☐ Individual ☐ Family ☐ Employee/Spouse ☐ Parent/Child(ren)
Dependent 2	Name Phone Certificate (policy no.)	Began Ended	☐ Yes ☐ No	☐ Active ☐ Retiree	☐ Individual ☐ Family ☐ Employee/Spouse ☐ Parent/Child(ren)
Dependent 3	Name Phone Certificate (policy no.)	Began Ended	☐ Yes ☐ No	☐ Active ☐ Retiree	☐ Individual ☐ Family ☐ Employee/Spouse ☐ Parent/Child(ren)

SECTION 6: MEDICARE INFORMATION – For Medicare eligible only

Please provide a copy of the Medicare (HIB) card for each person listed below. If copies are not attached, we cannot process your Medicare benefits request.

APPLICANT

Medicare ID no.	HIB Suffix	Part A coverage start date	Part B coverage start date

SPOUSE

Medicare ID no.	HIB Suffix	Part A coverage start date	Part B coverage start date

DEPENDENT

Dependent name	Medicare ID no.	HIB Suffix	Part A coverage start date	Part B coverage start date

I understand that if I become Medicare eligible while I am covered under this contract, any benefits I am entitled to under this contract will be reduced by any amounts paid by Medicare for those services, whether or not I apply for or submit a claim to Medicare.

SECTION 7: APPLICANT SIGNATURE – I have read the Certification and Insurance Fraud Statement below.

Certification: I certify that I am electing coverage as an employee, or former employee, retiree, current or former dependent of an active employee, or retiree, and am eligible for group coverage under the terms and conditions of the group's contract. I make this election on behalf of all eligible dependents and myself. I understand that I am under a continuing obligation to notify the group of a change in my, or my dependent's, status; such change may result in a change of insurance status with Empire and that failure to make such notification may result in cancellation of the coverage by Empire. Any other Empire coverage will end upon issuance of this coverage. If I do not agree to transfer my other coverage with Empire to this coverage, I understand that this application will not be accepted by Empire.

I authorize any health care provider, health care payor or government agency to furnish to Empire or its designee all records pertaining to medical history, services rendered, and payments made regarding me or my dependents for use by Empire to administer the terms of my health benefits contract. I also authorize Empire to disclose such information to an Empire designee, my PCP and other providers, other payors, and the group contract holder, for purposes of continuity of care and medical management, disease management, health benefits contract administration, financial audits, and as otherwise required by law. The foregoing authorizations are valid for a maximum period of 24 months. If your Empire coverage remains in effect upon the expiration of 24 months from the date of this enrollment form, you will be required to reauthorize Empire or its designees to furnish all such records as described in this paragraph to the parties and for the purposes described in this paragraph for an additional authorization period. All statements and answers in this notice of election are true and are representations made to induce the issuance of the coverage. Any material misrepresentation may result in Empire's cancellation of coverage.

Insurance Fraud Statement: Any person who knowingly and with intent to defraud an insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact there to, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim or each such violation.

Applicant signature X	Print name	Date (MMDDYY)

EMPLOYER INFORMATION (this section must be filled in by your group benefits administrator)

Group name	Group no.	Group sub no.

Street address	City	State	ZIP code

Employee no.	Payroll/department location	Applicant's FT employment start date

Authorized Group Benefits Administrator signature X	Print name	Date (MMDDYY)

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