TRANSACTION FORM FOR GROUP ACCOUNTS

MEMBERSHIP / P.O. BOX 2820 • NEW YORK, NY 10116-2820

(Please read important information on back before completing this form)

INTERNAL USE ONLY
CONTROL NUMBER

I. SUBSCRIBER INFORMATION

LAST NAME	FIRST NAME	M.I.	TELEPHONE NUMBERS **HOME** **WORK** **FAX**
HOME ADDRESS (Include Apartment Number)			**SEX** ❒ Male ❒ Female **MARITAL STATUS** ❒ Single ❒ Married ❒ Other _____
CITY	STATE	ZIP CODE	**EMPLOYMENT STATUS** ❒ Employed ❒ Not-Employed ❒ Retired ❒ COBRA **PRIMARY LANGUAGE SPOKEN**

II. ENROLLMENT INFORMATION

NAME LAST	NAME FIRST	NAME M.I.	DATE OF BIRTH MO/DAY/YR	SOCIAL SECURITY NUMBER	SEX	RELATION-SHIP	MAILING ADDRESS (If different from above)	EMAIL ADDRESS	FULL TIME STUDENT (√)	ADD (√)	DELETE (√)	RACE/ETHNICITY (CODES BELOW)
SUBSCRIBER						SELF			X	X	X	
SPOUSE									X			
DEPENDENT												
DEPENDENT												
DEPENDENT												

III. OTHER CARRIER INFORMATION

Do you or any of your dependents have other health care coverage? ❒ **Yes** **Please complete this section** ❒ **No** **GO TO SECTION IV**

NAME OF OTHER INSURANCE CARRIER	TYPE OF CONTRACT ❒ Group ❒ Individual	NAME OF POLICY HOLDER LAST NAME	FIRST NAME	M.I.
CARRIER'S ADDRESS	CITY	STATE	ZIP CODE	POLICY NUMBER / EFFECTIVE DATE

IV. DID YOU HAVE PRIOR HEALTH COVERAGE

❒ **YES** **Please provide a 12-month history of all coverage in this section** ❒ **NO** **GO TO SECTION VI**

	NAME AND ADDRESS OF INSURER	TELEPHONE NUMBER OF INSURER	NAME OF POLICYHOLDER	POLICY I.D. NUMBER	EFFECTIVE DATE OF CURRENT OR PRIOR POLICY	TERMINATION DATE OF CURRENT OR PRIOR POLICY
HOSPITAL						
MEDICAL						

V. EMPLOYER INFORMATION

GHI CERTIFICATE NUMBER OR EMPLOYEE SOCIAL SECURITY NUMBER	DATE OF HIRE	EMPLOYEE WAITING PERIOD ❒ YES NUMBER OF WAITING PERIOD DAYS _____ ❒ NOT APPLICABLE NUMBER OF ACTIVE EMPLOYEES IN YOUR GROUP _____

Check one: ❒ New Enrollment ❒ Reinstatement ❒ Termination

STATUS CHANGE: ❒ Add Dependent ❒ Remove Dependent ❒ Address Change ❒ Name Change Reason for Change: _____

TRANSFER: ❒ To Another Carrier ❒ GHI Group # Change: From _____ To _____ Is applicant currently working at least 20 hours per week? ❒ Yes ❒ No

VI. SUBSCRIBER AUTHORIZATION

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim concerning any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act which is a crime, shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Subscriber Signature _____ Date _____

GROUP AUTHORIZATION

Authorized Signature _____ Date _____ Phone Number _____

VII. GROUP NAME AND ADDRESS

	EFFECTIVE DATE OF TRANSACTION	GHI GROUP NUMBER
	MEDICAL	MEDICAL
	HOSPITAL	HOSPITAL
	DENTAL	DENTAL

RACE/ETHNICITY CODES: (Optional) A = ASIAN, I = NATIVE AMERICAN OR ALASKAN NATIVE, B = BLACK OR AFRICAN AMERICAN, P = NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER, C = CAUCASIAN, O = OTHER, H = HISPANIC OR LATINO

SEE INFORMATION/EXPLANATION ON REVERSE SIDE

FORM# 6204K 25M 1/05

IMPORTANT INFORMATION

1- The subscriber must complete sections I through IV. The group plan administrator must complete section V. Both the subscriber and the administrator must complete section VI.

2- All effective dates of transactions may not exceed thirty (30) days retroactive from the next billing date.

3- For group accounts with student dependent coverage: A full-time dependent student is a person who meets all of the following conditions:

He/she is at least 19 years of age, unmarried, receives at least half of his/her support from the employee or member, and is enrolled full-time in an accredited educational institution. The institution must grant a degree or diploma. The student must be listed as a dependent when you enroll for coverage.

To enroll the dependent as a full-time student, attach a complete Student Dependent Certification Form or attach a copy of the most recent Bursar's receipt. See your group plan administrator for a Dependent Student Certification Form.

4- Failure to complete any part of this form (e.g., group number, reason for submission, certificate number, etc.) will delay the processing of the transaction.

5- Failure to have the proper signatures and authorization will require GHI to return this transaction form to the employer group administror.

Why We Ask You for Race/Ethnicity Information

National studies show that differences in access to health care occur along ethnic lines. In our effort to ensure that everyone we serve receives appropriate care, GHI, along with other health insurers, is collecting data on ethnicity with the goal of improving access to care and outcomes for groups who often have poorer results. Information will only be used by our Medical Department to improve access to needed care and will not be available to any other staff. Answering this question is voluntary.

GHI Web Site

For fast, convenient access to the latest claim status, eligibility, and benefits information, visit GHI's secure Web site at www.ghi.com. Available around the clock, on the site you can also find provider listings, order ID cards, view an online Explanation of Benefits, access wellness information, and much more.

Translation Services

If English is not your primary language and translation services are needed when calling GHI Customer Service, a representative can help you.