Empire BlueCross BlueShield

ENROLLMENT/CHANGE FORM

Thank you for choosing Empire. Please fill out **all** items in order for us to quickly and accurately process your enrollment. Make sure you use **blue or black ink only, fill in circles completely, print in capital letters, and stay within the boxes when writing.** Once you've completed this form, please sign in the space provided in Section 8.

PO Box 1407, Church Street Station, New York, NY 10008-1407
www.empireblue.com

1. REASON FOR ENROLLMENT/CHANGE

Complete section A, B or C.

A. New Enrollment/Addition (fill in one circle only)

- ○ **New Hire** Proof of employment is necessary for applicants in companies with 50 or fewer employees. Please submit NYS-45, payroll records or W-4 forms to establish employment.
- ○ **Open Enrollment**
- ○ **Status Change** (fill in one circle below)

Date of Change (MMDDYY)

- ○ Marriage ○ Newborn ○ Adoption ○ Retirement
- ○ Medicare Eligible (answer questions below)

Eligibility criteria (fill in one circle only) ○ 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)

- ○ Part-Time to Full-Time
- ○ COBRA/NYS Continuation of Coverage

Nature of COBRA/ NYS Event:

- ○ Other:

B. Change (fill in all circles that apply)

For all circles filled in below, please supply new information in Section 4.

- ○ Name ○ Address
- ○ HMO/Direct HMO Primary Care Physician (PCP)
- ○ Managed Dental Primary Care Dentist (PCD)
  If your company offers an Empire Dental plan

C. Cancel Coverage (fill in one circle only)

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

Spouse/Dependent

- ○ Death ○ Divorce
- ○ Dependent no longer eligible
- ○ Other:

Date of Event (MMDDYY)

2. BENEFITS SELECTION

Medical Insurance (fill in one circle only) ○ PPO ○ EPO ○ HMO ○ Direct HMO Indemnity: ○ Hospital/Medical **or** ○ Hospital Only ○ Other

○ DPOS ○ DSPOS ○ Empire Total Blue℠ Choice (HSA)† ○ Empire Total Blue℠ Choice (HRA)

† Empire will facilitate the opening of a Health Savings Account in your name, as directed by your Employer.

Coverage Type (fill in one circle only) ○ Individual ○ Husband/Wife ○ Parent/Child(ren) ○ Family

Dental Insurance‡ (fill in one circle only) ○ PPO Dental ○ Managed Dental ○ Voluntary Dental ○ Other Dental

‡ If your company offers an Empire Dental plan

Coverage Type (fill in one circle only) ○ Individual ○ Husband/Wife ○ Parent/Child(ren) ○ Family

3. CUSTOMER SERVICE SELECTION

activate at www.empireblue.com

Fill in **all** the circles of the following telephone and Internet services you wish to use:

- ○ I want a **secure, personalized website** at ***www.empireblue.com***. Send my activation information to my e-mail address in Section 4.
- ○ Whenever possible, send my plan information to me through ***www.empireblue.com*** instead of the mail.
- ○ I plan to continue using **1-800 numbers** to call customer service.

4. APPLICANT AND SPOUSE/DEPENDENT INFORMATION

Note: If you've chosen HMO/Direct HMO, 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

Last Name | First Name | MI

Social Security Number | Gender ○ M ○ F | Birth Date (MMDDYY) | Marital Status ○ Married ○ Single | Date of Marriage (MMDDYY)

E-mail Address

1718 ENR 0296B 10/04

4. APPLICANT AND SPOUSE/DEPENDENT INFORMATION (continued)

Applicant (cont.)

Home Phone

Daytime Phone

Home Address

Apt. No.

City

State

Zip

Occupation

Primary Language

PCP Last Name

PCP First Name

PCP Number

Current Patient of PCP? ◯ Y ◯ N

Primary Care Dentist (PCD) Last Name

PCD First Name

PCD Number

Current Patient of PCD? ◯ Y ◯ N

Spouse

Social Security Number

Birth Date (MMDDYY)

Gender ◯ M ◯ F

Primary Language (if different)

Last Name (if different)

First Name

MI

PCP Last Name

PCP First Name

PCP No.

Current Patient of PCP? ◯ Y ◯ N

Dependent 1

Social Security Number

Birth Date (MMDDYY)

Gender ◯ M ◯ F

Primary Language (if different)

Last Name (if different)

First Name

MI

PCP Last Name

PCP First Name

PCP No.

Current Patient of PCP? ◯ Y ◯ N

Relationship: ◯ Child ◯ FT Student ¥ ◯ Disabled Child §

Dependent 2

Social Security Number

Birth Date (MMDDYY)

Gender ◯ M ◯ F

Primary Language (if different)

Last Name (if different)

First Name

MI

PCP Last Name

PCP First Name

PCP No.

Current Patient of PCP? ◯ Y ◯ N

Relationship: ◯ Child ◯ FT Student ¥ ◯ Disabled Child §

Dependent 3

Social Security Number

Birth Date (MMDDYY)

Gender ◯ M ◯ F

Primary Language (if different)

Last Name (if different)

First Name

MI

PCP Last Name

PCP First Name

PCP No.

Current Patient of PCP? ◯ Y ◯ N

Relationship: ◯ Child ◯ FT Student ¥ ◯ Disabled Child §

¥ Must be age 19+ and attend accredited college or university. Submit proof with this form. Proof is required annually.

§ Please submit Request for Disabled Child form (HAC506) with this form; child must be age 19+.

5. OTHER COVERAGE INFORMATION

Do you currently have or have you had health insurance in the past 11 months?

Applicant — Fill in Yes or No

○ YES Coverage Start Date (MMDDYY): ☐☐☐☐☐☐ Coverage End Date (MMDDYY): ☐☐☐☐☐☐

Has the coverage been continuous during the past 11 months? ○ Yes ○ No

Will your current group insurance remain in effect after you enroll in this Empire plan? ○ Yes ○ No

Name of Other Insurance Carrier ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Your ID Number from Other Carrier ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Coverage Provided by Employer? ○ Yes ○ No Employment Status: ○ Active ○ Retired

Contract Type: ○ Husband/Wife ○ Individual ○ Parent/Child(ren) ○ Family

Coverage Type: ○ Hospital/Medical ○ Hospital Only ○ Medical Only ○ Other: ☐☐☐☐☐☐☐☐☐☐

○ NO

Does your spouse / dependent(s) currently have or have they had health insurance in the past 11 months?

Spouse / Dependent(s) — Fill in Yes or No

○ YES Coverage Start Date (MMDDYY): ☐☐☐☐☐☐ Coverage End Date (MMDDYY): ☐☐☐☐☐☐

Has the coverage been continuous during the past 11 months? ○ Yes ○ No

Will their current group insurance remain in effect after you enroll in this Empire plan? ○ Yes ○ No

○ My spouse has or has had the same coverage as I. Note: You do not need to fill out the rest of the spousal other coverage questions.

○ My dependents have or have had the same coverage as I. Note: You do not need to fill out the rest of the dependent other coverage questions.

Spouse

Name of Spouse's Other Carrier ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

ID Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Coverage Start Date (MMDDYY) ☐☐☐☐☐☐ Coverage End Date (MMDDYY) ☐☐☐☐☐☐ Coverage Provided by Employer? ○ Yes ○ No Employment Status: ○ Active ○ Retired

Contract Type: ○ Husband/Wife ○ Individual ○ Parent/Child(ren) ○ Family

Coverage Type: ○ Hospital/Medical ○ Hospital Only ○ Medical Only ○ Other: ☐☐☐☐☐☐☐☐☐☐

Dependent 1

Name of Dependent's Other Insurance Carrier ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

ID Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Coverage Start Date (MMDDYY) ☐☐☐☐☐☐ Coverage End Date (MMDDYY) ☐☐☐☐☐☐ Coverage Provided by Employer? ○ Yes ○ No Employment Status: ○ Active ○ Retired

Contract Type: ○ Husband/Wife ○ Individual ○ Parent/Child(ren) ○ Family

Coverage Type: ○ Hospital/Medical ○ Hospital Only ○ Medical Only ○ Other: ☐☐☐☐☐☐☐☐☐☐

Dependent 2

Name of Dependent's Other Insurance Carrier ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

ID Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Coverage Start Date (MMDDYY) ☐☐☐☐☐☐ Coverage End Date (MMDDYY) ☐☐☐☐☐☐ Coverage Provided by Employer? ○ Yes ○ No Employment Status: ○ Active ○ Retired

Contract Type: ○ Husband/Wife ○ Individual ○ Parent/Child(ren) ○ Family

Coverage Type: ○ Hospital/Medical ○ Hospital Only ○ Medical Only ○ Other: ☐☐☐☐☐☐☐☐☐☐

Dependent 3

Name of Dependent's Other Insurance Carrier ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

ID Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Coverage Start Date (MMDDYY) ☐☐☐☐☐☐ Coverage End Date (MMDDYY) ☐☐☐☐☐☐ Coverage Provided by Employer? ○ Yes ○ No Employment Status: ○ Active ○ Retired

Contract Type: ○ Husband/Wife ○ Individual ○ Parent/Child(ren) ○ Family

Coverage Type: ○ Hospital/Medical ○ Hospital Only ○ Medical Only ○ Other: ☐☐☐☐☐☐☐☐☐☐

○ NO

6. MEDICARE INFORMATION For Medicare eligible only.

Please provide a copy of your Medicare (HIB) card. If a copy is not attached, we cannot process your Medicare benefits request.

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.

Applicant Last Name | First Name | MI

Medicare ID Number | HIB Suffix | Part A Hospital Coverage Start Date (MMDDYY) | Part B Medical Coverage End Date (MMDDYY)

Spouse/Dependent's Last Name (if different) | First Name | MI

Medicare ID Number | HIB Suffix | Part A Hospital Coverage Start Date (MMDDYY) | Part B Medical Coverage End Date (MMDDYY)

7. EMPLOYER INFORMATION This section must be filled in by your group benefits administrator.

Group Name

Address

City | State | Zip

Applicant's Start Date of Full Time Employment (MMDDYY) | Payroll/Department Location | Employee Number

Group Number | Group Sub Number

8. SIGNATURES I have read the certification and fraud statement below.

Applicant Signature | Date (MMDDYY)

Printed Name and Signature of Authorized Group Benefits Administrator

Print | Signature | Date (MMDDYY)

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 healthcare provider, healthcare 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.

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 thereto, 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 for each such violation.