Empire BlueCross BlueShield

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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 7.

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** — **Date of Change (MMDDYY)** ☐☐☐☐☐☐
- ○ **Status Change** (fill in one circle below)
  - ○ 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 3.

- ○ Name ○ Address
- ○ HMO/Direct HMO/POS/DSPOS 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 3.

Spouse/Dependent

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

Date of Event (MMDDYY) ☐☐☐☐☐☐

2. BENEFITS SELECTION

Medical Insurance[1] (fill in one circle only) ○ PPO ○ EPO ○ HMO ○ Direct HMO Indemnity: ○ Hospital/Medical **or** ○ Hospital Only ○ Other
○ DPOS ○ DSPOS ○ Value EPO (small group only) ○ Empire Total Blue℠ Choice (HSA)
○ Empire Total Blue℠ Choice (HRA) ○ Empire Prism℠ PPO (large group only) ○ Empire Prism℠ EPO

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

Dental Insurance[2] (fill in one circle only) ○ PPO Dental ○ Managed Dental ○ Voluntary Dental ○ Other Dental

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

Vision Insurance[3] **Blue View Vision℠**
Coverage Type (fill in one circle only) ○ 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.

3. APPLICANT AND SPOUSE/DEPENDENT INFORMATION

Applicant

Note: If you've chosen HMO/Direct HMO/POS/DSPOS, 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.

Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ First Name ☐☐☐☐☐☐☐☐☐☐☐☐ MI ☐

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

Place of Marriage* (State and Country) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Country ☐☐☐☐☐☐

*Marriage must have been entered into in a jurisdiction that recognizes its validity

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