LEASE PRINT. *For address and/or primary care physician changes call (518) 641-3700, 1-800-777-2273, or visit www.cdphp.com* USE BLACK INK ONLY.

Enrollment Application/ Change Form

500 Patroon Creek Blvd.
Albany, NY 12206-1057
(518) 641-3700 or 1-800-777-2273

EMPLOYER USE ONLY

Date Hired (MM/DD/YY) *(required)* _____ ◯ Full-time ◯ Part-time (20 hours or less/week)

Date coverage is effective _____ ◯ Active ◯ COBRA

◯ Retiree 65 or older ◯ Retiree 55–65 ◯ Retiree Under 55

Date of status change _____ Employer Name _____

◯ Part- to full-time ◯ Union to non-union ◯ Other _____

Group/Subgroup #: _____ Class #: _____

Chamber Assoc: _____ **Grp Admin Initials *(required)*** _____

A. EXPLANATION Check all that apply

◯ New Hire ◯ Open Enrollment ◯ Loss of Coverage ◯ Marriage ◯ Birth ◯ Change in Student Status ◯ Dependent to 29

◯ Name/Address Change ◯ Court Order

◯ **COBRA**—*Reason:* ◯ Left Employ/Retirement ◯ Divorce/Legal Separation ◯ Death of Spouse ◯ Dependent Reached Max Age ◯ Loss of Student Status

◯ **Termination**—*Reason:* ◯ Employment Terminated ◯ Remove Dependents Only ◯ Deceased ◯ Other _____

B. COVERAGE INFORMATION

Product Type: ◯ HMO ◯ HDHMO ◯ EPO ◯ HDEPO ◯ PPO ◯ HDPPO ◯ HNY ◯ Crystal Run

PCP Copay Amt: $ _____ Specialist Copay Amt: $ _____ % Coins: _____ Deduct. Amt: $ _____ ◯ **Drug Coverage** ◯ **Dental Coverage**

Dental Coverage: ◯ Single ◯ Employee/Children ◯ Employee/Spouse ◯ Family

C. CONSUMER-DIRECTED HEALTH PLANS

I am participating in a CDPHP-administered:

◯ Flexible Spending Account ◯ Health Reimbursement Account ◯ Health Savings Account ◯ Not Applicable

D. SUBSCRIBER INFO

For **HMOs only**, you and each dependent **MUST** select a Primary Care Physician (PCP). Females may also choose one OB/GYN. Also indicate if a member is a current patient and get the Physician # and Office Location from the provider directory or at www.cdphp.com. **For all other products, include copy of your HIPAA certificate. If you have Medicare Parts A and B, include a copy of your Medicare card.**

1. Last Name | First Name | M.I. | 4. Telephone: Home | Work

2. Street Address | Apt. # | 5. E-mail Address

3. City | State | ZIP | 6. Employer Name

7. Social Security Number ***(Required)*** | Date of Birth | Add *or* Delete ◯ ◯

Sex: ◯ *M* ◯ *F* ◯ Disabled ◯ End-Stage Renal Disease

Medicare number: _____ Part A effective date: _____ Part B effective date: _____

Primary Language: _____

Ethnicity: ◯ White ◯ Black ◯ American Indian/Alaska Native ◯ Asian/Pacific Islander ◯ Hispanic/Latino ◯ Other

Previous coverage: ◯ *Yes* Previous carrier: _____ Effective from: _____ To: _____

HMO only—Physician (PCP) Last | First | M.I. | Office location | Phys # | Current Patient? ◯

OB/GYN Last | First | M.I. | Office location | Phys # | Current Patient? ◯

E. DEPENDENT INFO

8a. Last | First | M.I. | SSN ***(Required)*** | Date of Birth | Add *or* Delete ◯ ◯

Rel: ◯ *Spouse* ◯ *Other* Sex: ◯ *M* ◯ *F* ◯ Disabled ◯ End-Stage Renal Disease

Medicare number: _____ Part A effective date: _____ Part B effective date: _____

Primary Language: _____

Ethnicity: ◯ White ◯ Black ◯ American Indian/Alaska Native ◯ Asian/Pacific Islander ◯ Hispanic/Latino ◯ Other

Previous coverage: ◯ *Yes* Previous carrier: _____ Effective from: _____ To: _____

HMO only—Physician (PCP) Last | First | M.I. | Office location | Phys # | Current Patient? ◯

OB/GYN Last | First | M.I. | Office location | Phys # | Current Patient? ◯

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E. DEPENDENT INFO *Cont'd*

For **HMOs only**, you and each dependent **MUST** select a Primary Care Physician (PCP). Females may also choose one OB/GYN. Also indicate if a member is a current patient and get the Physician # and Office Location from the provider directory or at www.cdphp.com. **For all other products, include copy of your HIPAA certificate. If you have Medicare Parts A and B, include a copy of your Medicare card.**

8b. Last | First | M.I. | SSN ***(Required)*** | Date of Birth | Add *or* Delete ○ ○

Rel: ○ *Son* ○ *Daughter* ○ *Full-time student?* ○ Disabled ○ End-Stage Renal Disease

Medicare number: _____ Part A effective date: _____ Part B effective date: _____

Primary Language: _____

Ethnicity: ○ White ○ Black ○ American Indian/Alaska Native ○ Asian/Pacific Islander ○ Hispanic/Latino ○ Other

School name *(if student)* | Expected date of graduation | School address *(City, State, ZIP)*

Previous coverage: ○ *Yes* Previous carrier: _____ Effective from: _____ To: _____

HMO only—Physician (PCP) Last | First | M.I. | Office location | Phys # | Current Patient? ○

OB/GYN Last | First | M.I. | Office location | Phys # | Current Patient? ○

8c. Last | First | M.I. | SSN ***(Required)*** | Date of Birth | Add *or* Delete ○ ○

Rel: ○ *Son* ○ *Daughter* ○ *Full-time student?* ○ Disabled ○ End-Stage Renal Disease

Medicare number: _____ Part A effective date: _____ Part B effective date: _____

Primary Language: _____

Ethnicity: ○ White ○ Black ○ American Indian/Alaska Native ○ Asian/Pacific Islander ○ Hispanic/Latino ○ Other

School name *(if student)* | Expected date of graduation | School address *(City, State, ZIP)*

Previous coverage: ○ *Yes* Previous carrier: _____ Effective from: _____ To: _____

HMO only—Physician (PCP) Last | First | M.I. | Office location | Phys # | Current Patient? ○

OB/GYN Last | First | M.I. | Office location | Phys # | Current Patient? ○

8d. Last | First | M.I. | SSN ***(Required)*** | Date of Birth | Add *or* Delete ○ ○

Rel: ○ *Son* ○ *Daughter* ○ *Full-time student?* ○ Disabled ○ End-Stage Renal Disease

Medicare number: _____ Part A effective date: _____ Part B effective date: _____

Primary Language: _____

Ethnicity: ○ White ○ Black ○ American Indian/Alaska Native ○ Asian/Pacific Islander ○ Hispanic/Latino ○ Other

School name *(if student)* | Expected date of graduation | School address *(City, State, ZIP)*

Previous coverage: ○ *Yes* Previous carrier: _____ Effective from: _____ To: _____

HMO only—Physician (PCP) Last | First | M.I. | Office location | Phys # | Current Patient? ○

OB/GYN Last | First | M.I. | Office location | Phys # | Current Patient? ○

F. OTHER INSURANCE

Do you, your spouse, or any of your dependents have any other medical insurance that will be maintained in addition to CDPHP? ○ Yes: *If yes, complete below.* ○ No

a. Policyholder name | Policy # | Insurance carrier | Employer name

Date of birth: _____ Address: _____

Effective date: _____ Coverage type: ○ Hospital ○ Medical ○ Drug ○ Dental ○ Vision

Covered Individuals—*Check all that apply* ○ Self ○ Spouse ○ Dependents

Note: Make sure you sign and date the application on the next page.

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G. SIGNATURE: AGREEMENT: I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge and that I have read the important information on the last page of this form.

Any person who knowingly and with intent to defraud any 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 fact material 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.

10. Applicant's Signature: _____ 11. Date: _____

IMPORTANT INFORMATION

Failure to complete any sections will result in a processing delay of your application, member ID cards and, claims payment. Failure by your employer to complete the employer section will also result in a delay.

If you should have any questions about this Enrollment Application/Change Form, please call the CDPHP® member services department at (518) 641-3700 or 1-800-777-2273. Thank you for choosing CDPHP for your health care coverage.

Your signature on this application hereby affirms the following:

On behalf of myself and any dependents listed, I hereby apply for coverage under the Master Group Contract (health and/or dental, as the case may be) issued to my employer by Capital District Physicians' Health Plan, Inc. and/or CDPHP Universal Benefits,® Inc. (CDPHP UBI) and/or Delta Dental of New York, Inc.

I understand that the benefits for which I (we) will be eligible are in accordance with those described in the Master Group Contract and any attached riders. I further understand that for HMO benefits provided by Capital District Physicians' Health Plan, Inc., except for emergencies, covered services must be obtained through a participating physician (unless otherwise noted in rider) or in a participating hospital (unless otherwise noted in rider) when admitted or referred by a participating physician (unless otherwise noted in rider), and also that certain services may require a copayment (unless otherwise noted in rider) by me (or my dependents) directly to the provider of such services.

I hereby permit my employer to deduct the necessary Health Services Fees, if any, from my wages or salary, with the understanding that the employer acts as my agent in all dealings with CDPHP and/or Delta Dental of New York, Inc., and that all acts performed by the employer and all notices given to the employer in such dealings are binding upon me, as not prohibited by statute or regulation.

I understand that unresolved grievances are subject to the procedure specified in the Master Group Contract.

Note: CDPHP UBI coverage may have a pre-existing condition clause. Please consult your benefit materials or check with your personnel office for more specific information.

CDPHP COMPANIES
Capital District Physicians' Health Plan, Inc.
CDPHP Universal Benefits,® Inc.
Capital District Physicians' Healthcare Network, Inc.

Delta Dental Service Plans are underwritten and administered by Delta Dental of New York, Inc.

Delta Dental of New York
One Delta Drive
Mechanicsburg, PA 17055
1-800-932-0783
TTY/TDD 1-888-373-3582
www.deltadentalins.com