

Enrollment/Change Form



An Anthem Company

Thank you for choosing Empire BlueCross BlueShield (Empire). So that we may quickly and accurately process your enrollment, please complete in full and sign in section 6.

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

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

<input type="checkbox"/> New hire Must indicate start date of full time employment in section 7. Leave Date of Change field blank.	Date of change (MM/DD/YY)
<input type="checkbox"/> Open enrollment Leave Date of Change field blank	
<input type="checkbox"/> Status change – Select only one	
<input type="checkbox"/> Marriage <input type="checkbox"/> Newborn <input type="checkbox"/> Adoption <input type="checkbox"/> Retirement <input type="checkbox"/> Medicare eligible For Medicare eligible only, answer the following questions: Eligibility criteria – Select only one <input type="checkbox"/> Age 65+ <input type="checkbox"/> Disability <input type="checkbox"/> End-stage renal disease Active employee? <input type="checkbox"/> Yes <input type="checkbox"/> No Electing company coverage as primary coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No Electing Medicare-related coverage as primary coverage? ... <input type="checkbox"/> Yes <input type="checkbox"/> No (If company size is under 20 employees and endstage renal disease does not apply, you must choose this option)	
<input type="checkbox"/> Mandatory Right of Election – NYS Qualified dependents only. Must complete Section 3.	
<input type="checkbox"/> Original COBRA/NYS Continuation of coverage (MM/DD/YY) _____ Nature of COBRA/NYS event _____	
<input type="checkbox"/> Loss of Coverage Must indicate last day covered in section 5.	
<input type="checkbox"/> Other: _____	

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

<input type="checkbox"/> Name <input type="checkbox"/> Address <input type="checkbox"/> Primary Care Physician (PCP) (HMO and POS plans only)	<input type="checkbox"/> Managed Dental Primary Care Dentist (PCD) (If your company offers an Empire Dental plan)	Date of change (MM/DD/YY)
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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.

<input type="checkbox"/> Spouse/Dependent <input type="checkbox"/> Death <input type="checkbox"/> Divorce <input type="checkbox"/> Dependent no longer eligible <input type="checkbox"/> Other	Date of event (MM/DD/YY)
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SECTION 2: BENEFITS SELECTION

Medical Insurance¹ Select only one plan type:

Large group plans (101+ eligibles)

<input type="checkbox"/> HMO	<input type="checkbox"/> Empire Prism SM EPO	<input type="checkbox"/> Empire Total Blue EPO (HSA)	<input type="checkbox"/> PPO	<input type="checkbox"/> Direct POS
<input type="checkbox"/> HMO with Blue Priority network ²	<input type="checkbox"/> Empire Prism EPO	<input type="checkbox"/> Empire Total Blue EPO HSA with Blue Priority network ²	<input type="checkbox"/> Empire Prism SM PPO	<input type="checkbox"/> DS POS
<input type="checkbox"/> Direct HMO	<input type="checkbox"/> Empire Prism EPO Select	<input type="checkbox"/> Empire Total Blue EPO (HRA)	<input type="checkbox"/> Empire Total Blue PPO (HSA)	
<input type="checkbox"/> EPO		<input type="checkbox"/> Empire Total Blue EPO HRA with Blue Priority network ²	<input type="checkbox"/> Empire Total Blue PPO (HRA)	

Indemnity Select only one coverage type: Hospital/Medical or Hospital Only Other: _____

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

Dental Insurance³ Select only one coverage type: PPO Dental Managed Dental Voluntary Dental Other Dental
 Individual Employee/Spouse Parent/Child(ren) Family

Vision Insurance⁴ Blue View VisionSM 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 The Blue Priority network includes selected physicians from our networks.
 3 If your company offers an Empire Dental Plan. 4 If your company offers a Blue View Vision plan.

SECTION 3: APPLICANT INFORMATION

Last name		First name			M.I.	Social Security no. ⁵ (required)	
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth (MM/DD/YY)	Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married	Marriage date (MM/DD/YY)	Home phone no.	Daytime phone no.		
Street address				Apt. no.	Home phone no.		
City			State	ZIP code	Daytime phone no.		
Occupation				Primary language			
Email address (requested for ages 18 and over):					<input type="checkbox"/> Yes, information may be sent to me electronically.		
Please provide a copy of the Medicare (HIB) card.			Medicare ID no.	Part A coverage start date	Part B coverage start date		

5 Empire is required by the Internal Revenue Service to collect this information.

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

If you chose HMO/Direct HMO/ Direct 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 members except for emergency and urgent care. If you chose 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
Primary care dentist (PCD) last name	Primary care dentist (PCD) first name	PCD no.	Current patient of PCD? <input type="checkbox"/> Yes <input type="checkbox"/> No

SPOUSE DOMESTIC PARTNER

Last name	First name	M.I.	Social Security no. ¹ (required)
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Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth (MM/DD/YY)	Primary language, if different
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PCP last name	PCP first name	PCP no.	Current patient of PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Email address (requested for ages 18 and over): Yes, information may be sent to me electronically.

Please provide a copy of the Medicare (HIB) card.	Medicare ID no.	Part A coverage start date	Part B coverage start date
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DEPENDENT 1

Last name	First name	M.I.	Social Security no. ¹ (required)
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Sex <input type="checkbox"/> M <input type="checkbox"/> F	Married? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of birth (MM/DD/YY)	Primary language, if different
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PCP last name	PCP first name	PCP no.	Current patient of PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Email address (requested for ages 18 and over): Yes, information may be sent to me electronically.

Relationship: Child Full-time student² Disabled child³ Make available age 29 adult dependent child

Please provide a copy of the Medicare (HIB) card.	Medicare ID no.	Part A coverage start date	Part B coverage start date
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DEPENDENT 2

Last name	First name	M.I.	Social Security no. ¹ (required)
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Sex <input type="checkbox"/> M <input type="checkbox"/> F	Married? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of birth (MM/DD/YY)	Primary language, if different
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PCP last name	PCP first name	PCP no.	Current patient of PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Email address (requested for ages 18 and over): Yes, information may be sent to me electronically.

Relationship: Child Full-time student² Disabled child³ Make available age 29 adult dependent child

Please provide a copy of the Medicare (HIB) card.	Medicare ID no.	Part A coverage start date	Part B coverage start date
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DEPENDENT 3

Last name	First name	M.I.	Social Security no. ¹ (required)
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Sex <input type="checkbox"/> M <input type="checkbox"/> F	Married? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of birth (MM/DD/YY)	Primary language, if different
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PCP last name	PCP first name	PCP no.	Current patient of PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Email address (requested for ages 18 and over): Yes, information may be sent to me electronically.

Relationship: Child Full-time student² Disabled child³ Make available age 29 adult dependent child

Please provide a copy of the Medicare (HIB) card.	Medicare ID no.	Part A coverage start date	Part B coverage start date
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¹ Empire is required by the Internal Revenue Service to collect this information.
² Child must exceed contractual dependent age and attend accredited college or university. Submit proof with this form. Proof is required annually.
³ 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:

Names(s) of person(s) (first, M.I., last)	Insurance company information	Coverage Dates	Will coverage remain active?	Provided by employer?	Employment status	Contract type
Self	Carrier Name Policyholder Name Phone Certificate (policy no.)	First day covered Last day covered	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> COBRA/NYS Continuation of coverage <input type="checkbox"/> Active <input type="checkbox"/> Retiree	<input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Parent/Child(ren)
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	Carrier Name Policyholder Name Phone Certificate (policy no.)	First day covered Last day covered	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> COBRA/NYS Continuation of coverage <input type="checkbox"/> Active <input type="checkbox"/> Retiree	<input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Parent/Child(ren)
Dependent 1	Carrier Name Policyholder Name Phone Certificate (policy no.)	First day covered Last day covered	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> COBRA/NYS Continuation of coverage <input type="checkbox"/> Active <input type="checkbox"/> Retiree	<input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Parent/Child(ren)
Dependent 2	Carrier Name Policyholder Name Phone Certificate (policy no.)	First day covered Last day covered	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> COBRA/NYS Continuation of coverage <input type="checkbox"/> Active <input type="checkbox"/> Retiree	<input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Parent/Child(ren)
Dependent 3	Carrier Name Policyholder Name Phone Certificate (policy no.)	First day covered Last day covered	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> COBRA/NYS Continuation of coverage <input type="checkbox"/> Active <input type="checkbox"/> Retiree	<input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Parent/Child(ren)

SECTION 6: 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.

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.

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 payers, 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 authorization in the foregoing sentence is 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 may 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.

I certify each Social Security Number submitted is correct.

Applicant signature X	Print name	Date (MM/DD/YY)
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SECTION 7: 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 full-time employment start date
Authorized Group Benefits Administrator signature X	Print name	Date (MM/DD/YY)

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