# **HIP** Subscriber/Member Enrollment Form

| Last Name | | First Name | M I | Sex | Social Security Number |
|---|---|---|---|---|---|

| Street Address | Apt | City | | State | Zip Code |
|---|---|---|---|---|---|

Were you ever a member of HIP? ☐ NO ☐ YES
If yes, indicate member ID number(s): _____

**Marital Status**
☐ Single
☐ Married ☐ Divorced

**Birth Date** Mo. | Day | Yr

Telephone #: Home: ( ___ ) _____ Work: ( ___ ) _____
E-Mail Address: _____

**Primary Care Physician:**
(not required for EPO/PPO members)
**Physician Name**

**OB/GYN Selection:**
(Optional)
**Physician Name**

**Physician ID Number**

**Physician ID Number**

**Prior Health Insurance Information**

Carrier Name _____

Coverage Begin Date __/__/__   Coverage End Date __/__/__

**Qualifying Event:** ☐ Birth/Adoption ☐ Marriage ☐ Loss of Coverage ☐ New Hire ☐ _____ **Qualifying Event Date:** Mo.____ Day____ Yr.

Are you covered by any other Health Insurance or Medicare?
☐ NO ☐ YES If yes, indicate:
Insurance Co. Name: _____
Insurance Co Telephone #: _____
Type of Coverage: _____
Policy #: _____ Effective Date: ___/___/___

Is your spouse covered by any other Health Insurance or Medicare?
☐ NO ☐ YES If yes, indicate:
Insurance Co Name: _____
Insurance Co. Telephone #: _____
Type of Coverage: _____
Policy #: _____ Effective Date: ___/___/___

*If you are enrolling for your spouse and/or children, please list each one below – see Election of Coverage for eligibility*

| Last Name (if different) | First Name | Soc. Sec. No. | Sex | Relationship | Birth Date Mo. \| Day \| Yr | Check if disabled | Primary Care Physician Name/Number (not required for EPO/PPO members) | OB/GYN Selection Name/Number (Optional) |
|---|---|---|---|---|---|---|---|---|
| SPOUSE | | | | ☐ Wife ☐ Husband ☐ Other | | | | |
| Prior Health Insurance Information | Carrier Name _____ | | | Coverage Begin Date __/__/__ Coverage End Date __/__/__ | | | | |
| ADDITIONAL DEPENDENTS (List oldest first) | | | | ☐ Son ☐ Daughter | | | | |
| Prior Health Insurance Information | Carrier Name _____ | | | Coverage Begin Date __/__/__ Coverage End Date __/__/__ | | | | |
| | | | | ☐ Son ☐ Daughter | | | | |
| Prior Health Insurance Information | Carrier Name _____ | | | Coverage Begin Date __/__/__ Coverage End Date __/__/__ | | | | |
| | | | | ☐ Son ☐ Daughter | | | | |
| Prior Health Insurance Information | Carrier Name _____ | | | Coverage Begin Date __/__/__ Coverage End Date __/__/__ | | | | |
| | | | | ☐ Son ☐ Daughter | | | | |
| Prior Health Insurance Information | Carrier Name _____ | | | Coverage Begin Date __/__/__ Coverage End Date __/__/__ | | | | |

*Your signature is required to process this form. Your signature attests that you have read the reverse side of this form*

Applicant must sign here: _____       Date _____

### THIS SECTION TO BE COMPLETED BY EMPLOYER/CONTRACTOR GROUP

| Name of Group | Group Number | **Select One:** ☐ HIP PRIME HMO ☐ HIP PRIME POS ☐ HIP SELECT EPO | ☐ HIPaccess I ☐ HIPaccess II ☐ HIP SELECT PPO | ☐ HIP PRIME EPO ☐ HIP PRIME PPO ☐ HIP CLASSIC HMO |
|---|---|---|---|---|
| Requested Effective Date \| Hire Date \| Employee Title \| Date Submitted to HIP \| Approved by (Representative of Benefits Administrator) | | **Type of Coverage:** ☐ Individual ☐ Employee & Spouse | ☐ Family ☐ Employee & Child | |

**Instructions to Benefit Administrators or Group Representatives:** For Groups with 50 employees or less, you **MUST** complete Section A on the reverse side of this form. Required documentation MUST be attached to this Enrollment Form to be processed

**FOR HIP USE ONLY**

| PROCESSED BY | RECEIVED DATE | PROCESSED DATE |
|---|---|---|

FORM 16-1613  1/04

HIP HEALTH PLAN OF NEW YORK, P.O. Box 2806, New York, NY 10116-2806

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# ELECTION OF COVERAGE

I am enrolling for coverage for myself, my spouse and unmarried children under the age limit shown on the group schedule of benefits who are full time students at an accredited educational institution and who are dependent on me and/or my spouse for support.

If I am required to contribute to the premium for my coverage, I hereby authorize my employer to deduct such contributions in advance from wages due me and to remit same to HIP.

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 be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

HIP PRIME POS and HIP*access* II applicants please note that your benefits are provided under two separate contracts: a HIP HMO contract issued by the Health Insurance Plan of Greater New York, and a HIP PRIME POS and/or HIP*access* II contract issued by the HIP Insurance Company of New York. Both contracts will end simultaneously if your HIP PRIME POS or HIP*access* II coverage ends.

## *The following paragraph pertains to small business groups only.*

I understand that pre-existing conditions will not be covered during the first 12 months of my enrollment under my group's contract. A pre-existing condition is a condition (whether physical or mental) regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended by a duly licensed medical professional or received within the six (6) month period ending on the enrollment date. Except that, pregnancy is not considered a pre-existing condition and genetic information may not be treated as a pre-existing condition in the absence of a diagnosis of the condition related to such genetic information. HIP will credit the time I/we were covered by the previous policy, provided that the break in coverage under this plan does not exceed sixty-three (63) days, exclusive of any waiting periods. I agree that after enrolled, I will upon request provide HIP and/or my medical group with information on pre-existing conditions and any previous coverage I had. Subject to the applicable State and Federal laws pertaining to pre-existing conditions and creditable coverage, benefits for pre-existing conditions may not be payable for up to twelve months from my effective date under my group's contract.

# SECTION A

**(To be completed by Benefits Administrator)**

# DOCUMENTATION BASED ON GROUP SIZE

Group Type (Check One) ➡

| ACTION Check (✔)One | Qualifying Event | Documentation Required | ☐ Sole Proprietorship or One Subscriber Group | ☐ Association of Two or More Employees | ☐ Small Group - Less Than 50 Employees |
|---|---|---|---|---|---|
| ☐ Add Subscriber | New Hire **or** Change in Plan | For eligible employees who work more than 20 hours weekly provide a recent Copy of NYS45 showing this subscriber as an employee **or** copy of Payroll documentation reflecting the date, employee's name and Social Security # **or** the employee's current year W4 form. | Not Eligible | | |
| ☐ Add Spouse | Marriage | Marriage Certificate | | | |
| ☐ Add Dependent | Birth | ☐ Birth Certificate or | | | |
| | Adoption | ☐ Formal Adoption Papers or | | | |
| | | ☐ Court Approved Guardianship Papers | | | |
| ☐ Add Spouse | Loss of Coverage | | | | |
| ☐ Add Dependent | | Certificate of Creditable Coverage | | | |

**Note:** *No Retroactive Enrollments will be allowed. Members must be enrolled within 30 days from the Qualifying Event.*

RETURN TO HIP

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