Enrollment/Change Form



Thank you for choosing Empire. Please fill please sign in the space provided in Secti		rder for us to quickly	and accur	rately proces	ss your e	nrollment.	Once y	ou've co	omplete	ed thi	s forn	n,
Applicant name (last, first, M.I.)	COMPLETE SECTIO	DN A, B OR C)										
A. NEW ENROLLMENT/ADDITION (FILL IN												
New hire (Proof of employment is new Please submit NYS-45, pay	cessary for applic				/ees.			Date of c	hange ((MMD)	DYYYY I I	')
🗆 Open enrollment									1			I
 Status change (fill in one box) Marriage Newborn Medicare eligible (answer quest Eligibility criteria (fill in one box Active employee Electing company coverage as p Electing Medicare-related cover (If company size is under 20 em) 	conly) primary coverage? rage as primary co	□ ? □ overage? □	Age 65+ Yes Yes Yes Jes not ap	☐ Disab ☐ No ☐ No ☐ No □ No □ pply, you mu		□ End s	-	enal dise	ase			
\Box Part-time to Full-time												
\Box Mandatory Right of Election – NYS	(qualified depend	lents must submit req	uired Adu	lt Dependen	t Electio	n and Eligi	bility Fo	orm)				
COBRA/NYS Continuation of coverage	ge Nature	e of COBRA/NYS event										
□ Other												
B. CHANGE (FILL IN ALL BOXES THAT APP	PLY)											
For all boxes filled in below, please supp	ly new informatio	n in Section 3.										
	imary Care Physic MO/Direct HMO/D	cian (PCP) Direct POS/Empire POS	S plans on			d Dental Pi company o)	
C. CANCEL COVERAGE (FILL IN ONE BOX (ONLY)											
Note: If you are canceling your own cove appropriate box below and enter the nar					ation For	rm. For oth	er cano	cellation	s, plea	se fill	in the	9
Spouse/Dependent 🗆 Deat		Divorce 🗆	Dependen	nt no longer (eligible			Date of e	event (N	1MDD)	(YYY) 	
2. BENEFITS SELECTION												
Medical Insurance ¹ (fill in one box only)	🗆 HMO	Blue sM Choice (HSA) sM EPO	□ EP0 □ DP0 □ Emp	roup only ☐ PPO S ☐ DSP ire Total Blue ire Prism sm P	'OS e sM Choic	ce (HRA)	□ V □ E □ E □ E	<i>Il group</i> alue EPC mpire PI mpire PI mpire EI mpire EI))S 20 20 Plus 20 Step	ped		
Indemnity:	🗆 Hospital/Me	dical or 🗆 Hospita	l Only	🗆 Other								
Coverage type (fill in one box only)	\Box Individual	🗆 Employee/Spous	se D	□ Parent/Ch	ild(ren)	🗆 Famil	у					
Dental Insurance ² (fill in one box only) Coverage type (fill in one box only)	□ PPO Dental □ Individual	□ Managed Dental □ Employee/Spous		□ Voluntary □ Parent/Ch		🗆 Othei 🗆 Famil		I				
Vision Insurance ³ Blue View Vision sm												
Coverage type (fill in one box only)	\Box Individual	🗆 Employee/Spous	se D	□ Parent/Ch	ild(ren)	🗆 Famil	у					
1 Empire will facilitate the opening of a Health Savings 2 If your company offers an Empire Dental Plan. 3 If your company offers a Blue View Vision plan.	s Account in your name,	as directed by your Employe	er.									

Services provided by Empire HealthChoice HMO, Inc. and/or Empire HealthChoice Assurance, Inc., licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

3. APPLICANT AND SPOUSE/DOMESTIC PAR	TNER/DEPENDENT	INFORMATION						
APPLICANT								
Note: If you've chosen HMO/Direct HMO/Direct POS/I network benefits are available to HMO/Direct HMO me								
Last name		First name			M.I.	Socia	al Security	/ no.
Gender	Birthdate (MMDD)	ΥΥΥΥ)	Marital stat	US			Date of m	arriage (MMDDYYYY)
🗆 Male 🛛 Female			🗆 Married	🗆 Sing	le			
Place of marriage*	State	Country						
Home address								Apt no.
City							State	e ZIP code
Home phone	Daytime phone		Pri	imary langu	age			
Occupation								
PCP Last name	PCP First	st name			PCP no.			Current patient of PCP?
								🗆 Yes 🗆 No
Primary Care Dentist (PCD) Last name	PCD First	st name			PCD no.			Current patient of PCD?
								🗆 Yes 🛛 No
SPOUSE DOMESTIC PARTNER			<u> </u>					
Last name (if different)		First name			M.I.	Socia	al Security	/ no.
Gender		Birthdate (MMDD)YYYY)	Prim	nary language (if differen	t)	<u> </u>
🗆 Male 🛛 Female								
PCP Last name	PCP Firs	st name			PCP no.			Current patient of PCP?
								🗆 Yes 🛛 No
DEPENDENT 1								
Last name (if different)		First name			M.I.	Socia	al Security	/ no.
Gender Marital status		Birthdate (MMDD)ΥΥΥΥ)	Prim	nary language (if differen	t)	
□ Male □ Female □ Married □] Single							
PCP Last name	PCP Firs	st name			PCP no.		- '	Current patient of PCP?
								🗆 Yes 🗆 No
	ſstudent** 🗆] Disabled child**	* 🗆 Make	available a	age 29 depend	lent child	****	
Relationship: \Box Child \Box FT					· · ·			
Relationship: Child FT DEPENDENT 2								
•		First name			M.I.	Socia	al Security	/ no.
DEPENDENT 2		First name			M.I.	Socia	al Security	
DEPENDENT 2		First name	 YYYY)	Prim	M.I. 			/ no.
DEPENDENT 2 Last name (if different) Gender Marital status	Single		 YYYY) 1 1	Prim				/ no.
DEPENDENT 2 Last name (if different) Gender Marital status] Single PCP Firs	Birthdate (MMDD	 IYYYY) 	Prin			t)	r no.
DEPENDENT 2 Last name (if different) Gender Marital status Male Female Married		Birthdate (MMDD)YYYY) 		nary language (t)	

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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 DOMESTIC PARTNER Name of Spouse's other insurance carrier ID no. Coverage start date (MMDDYYYY) Coverage end date (MMDDYYYY) Coverage provided by employer? Yes No Employee/Spouse Individual Coverage type: Hospital only Hospital only Parent/Child(ren) Coverage type: Hospital only Hospital only												
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Coverage start date (MMDDYYYY) Coverage end date (MMDDYYYY) Coverage end date (MMDDYYYY) Coverage provided by employer? Yes No Employment status Active Retired Contract type: Employee/Spouse Individual Description Coverage type: Hospital only	SPOUSE DOMESTIC PARTNER											
Coverage provided by employer? Yes No Employment status Active Retired Contract type: Employee/Spouse Individual Coverage type: Hospital only Hospital/Medical Medical only Parent/Child(ren) Parent/Child(ren) Coverage type: Hospital only Hospital/Medical Medical only	Name of Spouse's other insurance carrier	ID no. 										
Coverage provided by employer? Yes No Employment status Active Retired Contract type: Employee/Spouse Individual Coverage type: Hospital only Hospital/Medical Medical only Parent/Child(ren) Parent/Child(ren) Coverage type: Hospital only Hospital/Medical Medical only	Coverage start date (MMDDYYYY)	Coverage end date (MMDDYYYY)										
Contract type: Employee/Spouse Individual Coverage type: Hospital only Hospital/Medical Medical only Employee/Spouse Parent/Child(ren) Parent/Child(ren) Hospital only Hospital only Hospital only												
	Contract type:											

DEPENDENT 1 Name of dependent's other insurance carrier Coverage start date (MMDDYYYY) Coverage provided by employer? Yes Contract type: Employee/Spouse Individual Family Parent/Child(ren) DEPENDENT 2 Name of dependent's other insurance carrier Coverage start date (MMDDYYYY) Coverage start date (MMDDYYYY) Coverage provided by employer? Yes	ID no. ID no. Coverage end date (MMDDYYYY) Employment status Active Coverage type: Hospital only Hospital/Medical Medical only Other ID no.							
Coverage start date (MMDDYYYY) Coverage provided by employer? Yes Contract type: Employee/Spouse Individual Family Parent/Child(ren) DEPENDENT 2 Name of dependent's other insurance carrier Name of dependent's other insurance carrier Coverage start date (MMDDYYYY)	Coverage end date (MMDDYYYY) I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I <td< td=""></td<>							
Coverage provided by employer? Yes No Contract type: Employee/Spouse Individual Family Parent/Child(ren) DEPENDENT 2 Name of dependent's other insurance carrier Image: Coverage start date (MMDDYYYY) Image: Coverage start date (MMDDYYYY)	Employment status Active Retired Coverage type: Hospital only Hospital/Medical Medical only 0 ther 0 1 1 1 1							
Coverage provided by employer? Yes No Contract type: Employee/Spouse Individual Family Parent/Child(ren) DEPENDENT 2 Name of dependent's other insurance carrier Image: Coverage start date (MMDDYYYY) Image: Coverage start date (MMDDYYYY)	Employment status Active Retired Coverage type: Hospital only Hospital/Medical Medical only 0 ther 0 1 1 1 1							
Contract type: Employee/Spouse Individual □ Family Parent/Child(ren) DEPENDENT 2 Name of dependent's other insurance carrier □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	Coverage type: Hospital only Hospital/Medical Medical only Other I <lii< li=""> I</lii<>							
Family Parent/Child(ren) DEPENDENT 2 Parent/Child(ren) Name of dependent's other insurance carrier Parent/Child(ren) Coverage start date (MMDDYYYY) Parent/Child(ren)	□ 0ther							
DEPENDENT 2 Name of dependent's other insurance carrier Operation Overage start date (MMDDYYYY)								
Name of dependent's other insurance carrier Coverage start date (MMDDYYYY)								
Coverage start date (MMDDYYYY)								
Coverage provided by employer? \Box Yes \Box No	Coverage end date (MMDDYYYY)							
	Employment status 🗆 Active 🗆 Retired							
Contract type: 🗌 Employee/Spouse 🗌 Individual	Coverage type: 🗌 Hospital only 🗌 Hospital/Medical 🗐 Medical only							
Family Parent/Child(ren)	□ Other							
DEPENDENT 3								
Name of dependent's other insurance carrier	ID no.							
Coverage start date (MMDDYYYY)	Coverage end date (MMDDYYYY)							
Coverage provided by employer? Yes No	Employment status 🗆 Active 🔅 Retired							
Contract type: 🗆 Employee/Spouse 🗀 Individual	Coverage type: 🛛 Hospital only 🗆 Hospital/Medical 🖾 Medical only							
□ Family □ Parent/Child(ren)	□ Other							
DEPENDENT 4								
Name of dependent's other insurance carrier	ID no.							
Coverage start date (MMDDYYYY)	Coverage end date (MMDDYYYY)							
Coverage provided by employer? Yes No	Employment status 🗆 Active 🔅 Retired							
Contract type:	Coverage type:							
□ Family □ Parent/Child(ren)	□ 0ther							
5. MEDICARE INFORMATION (FOR MEDICARE ELIGIBLE ONLY.)	Madiana frances							
Please provide a copy of your Medicare (HIB) card. If a copy is not attached,								
I understand that if I become Medicare eligible while I am covered under this by any amounts paid by Medicare for those services, whether or not I apply								
Applicant last name First name First name	M.I. Medicare ID no.							
HIB Suffix	Part A coverage start date Part B Medical coverage start date							
Spouse/Dependent's last name (if different) First name	M.I. Medicare ID no.							
HIB Suffix	Part A coverage start date Part B Medical coverage start date							

6. EMPLOYER INFORMATION (THIS SEC	CTION M	IUST BI	E FILL	ED IN	BY Y	OUR	GROU	P BE	ENEF	ITS A	DMI	NIST	RATO	R.)							
Group name															Group	no.			Group S	ub no.		
Address																						
City												Stat	e ZIP	code								
Employee no.				Payr	Payroll/Department location									App	olicant's	start date o	of full-time	e emplo	yment			
																		,	I			

7. APPLICANT SIGNATURE (I HAVE READ THE CERTIFICATION AND FRAUD STATEMENT BELOW.)

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 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 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 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.

Applicant signature	Print name	Date							
X									
Authorized Group Benefits Administrator signature	Print name	Date							
X									

Empire BlueCross BlueShield PO Box 1407, Church Street Station New York, NY 10008-1407

empireblue.com

