Enrollment/Change Form

Empire BlueCross BlueShield

Thank you for choosing Empire. Please fill out all items in order for us to quickly and accurately process your enrollment. Once you've completed this form, please sign in the space provided in Section 7.

Applicant name (last, first, M.I.)

1. REASON FOR ENROLLMENT/CHANGE *(COMPLETE SECTION A, B OR C)*

A. NEW ENROLLMENT/ADDITION (FILL IN ONE BOX 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.*)

Date of change (MMDDYYYY)

☐ **Open enrollment**

☐ **Status change** *(fill in one box)*

☐ Marriage ☐ Newborn ☐ Adoption ☐ Retirement

☐ Medicare eligible *(answer questions below)*

Eligibility criteria *(fill in one box 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**

☐ **Mandatory Right of Election — NYS** *(qualified dependents must submit required Adult Dependent Election and Eligibility Form)*

☐ **COBRA/NYS Continuation of coverage** Nature of COBRA/NYS event

☐ **Other**

B. CHANGE (FILL IN ALL BOXES THAT APPLY)

For all boxes filled in below, please supply new information in Section 3.

☐ Name ☐ Address ☐ Primary Care Physician (PCP) (HMO/Direct HMO/Direct POS/Empire POS plans only) ☐ Managed Dental Primary Care Dentist (PCD) *(If your company offers an Empire Dental plan)*

C. CANCEL COVERAGE (FILL IN ONE BOX 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 box 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 (MMDDYYYY)

2. BENEFITS SELECTION

Medical Insurance[1] *(fill in one box only)*

	Large group only	*Small group only*
☐ Direct HMO	☐ EPO ☐ PPO	☐ Value EPO
☒ HMO	☐ DPOS ☐ DSPOS	☐ Empire POS
☐ Empire Total Blue℠ Choice (HSA)	☐ Empire Total Blue℠ Choice (HRA)	☐ Empire PPO
☐ Empire Prism℠ EPO	☐ Empire Prism℠ PPO	☐ Empire PPO Plus
		☐ Empire EPO Stepped
		☐ Empire EPO Essential

Indemnity: ☐ Hospital/Medical **or** ☐ Hospital Only ☐ Other

Coverage type *(fill in one box only)* ☐ Individual ☐ Employee/Spouse ☐ Parent/Child(ren) ☐ Family

Dental Insurance[2] *(fill in one box only)* ☐ PPO Dental ☐ Managed Dental ☐ Voluntary Dental ☐ Other Dental

Coverage type *(fill in one box only)* ☐ Individual ☐ Employee/Spouse ☐ Parent/Child(ren) ☐ Family

Vision Insurance[3] **Blue View Vision℠**

Coverage type *(fill in one box 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/DOMESTIC PARTNER/DEPENDENT INFORMATION

APPLICANT

Note: If you've chosen HMO/Direct HMO/Direct POS/Empire 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/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 | M.I. | Social Security no.

Gender ☐ Male ☐ Female | Birthdate (MMDDYYYY) | Marital status ☐ Married ☐ Single | Date of marriage (MMDDYYYY)

Place of marriage* | State | Country

Home address | Apt no.

City | State | ZIP code

Home phone | Daytime phone | Primary language

Occupation

PCP Last name | PCP First name | PCP no. | Current patient of PCP? ☐ Yes ☐ No

Primary Care Dentist (PCD) Last name | PCD First name | PCD no. | Current patient of PCD? ☐ Yes ☐ No

☐ SPOUSE ☐ DOMESTIC PARTNER

Last name (if different) | First name | M.I. | Social Security no.

Gender ☐ Male ☐ Female | Birthdate (MMDDYYYY) | Primary language (if different)

PCP Last name | PCP First name | PCP no. | Current patient of PCP? ☐ Yes ☐ No

DEPENDENT 1

Last name (if different) | First name | M.I. | Social Security no.

Gender ☐ Male ☐ Female | Marital status ☐ Married ☐ Single | Birthdate (MMDDYYYY) | Primary language (if different)

PCP Last name | PCP First name | PCP no. | Current patient of PCP? ☐ Yes ☐ No

Relationship: ☐ Child ☐ FT student** ☐ Disabled child*** ☐ Make available age 29 dependent child****

DEPENDENT 2

Last name (if different) | First name | M.I. | Social Security no.

Gender ☐ Male ☐ Female | Marital status ☐ Married ☐ Single | Birthdate (MMDDYYYY) | Primary language (if different)

PCP Last name | PCP First name | PCP no. | Current patient of PCP? ☐ Yes ☐ No

Relationship: ☐ Child ☐ FT student** ☐ Disabled child*** ☐ Make available age 29 dependent child****

DEPENDENT 3

Last name (if different) | First name | M.I. | Social Security no.

Gender ☐ Male ☐ Female | Marital status ☐ Married ☐ Single | Birthdate (MMDDYYYY) | Primary language (if different)

PCP Last name | PCP First name | PCP no. | Current patient of PCP? ☐ Yes ☐ No

Relationship: ☐ Child ☐ FT student** ☐ Disabled child*** ☐ Make available age 29 dependent child****

DEPENDENT 4

Last name (if different) | First name | M.I. | Social Security no.

Gender ☐ Male ☐ Female | Marital status ☐ Married ☐ Single | Birthdate (MMDDYYYY) | Primary language (if different)

PCP Last name | PCP First name | PCP no. | Current patient of PCP? ☐ Yes ☐ No

Relationship: ☐ Child ☐ FT student** ☐ Disabled child*** ☐ Make available age 29 dependent child****

*Marriage must have been entered into in a jurisdiction that recognizes its validity.
**Child must exceed contractual dependent age and attend accredited college or university. Submit proof with this form. Proof is required annually.
***Please submit Request for Disabled Child form (HAC506) with this form; child age must exceed contractual dependent age.
****Qualified dependents must submit the required Adult Dependent Eligibility Form.

4. OTHER COVERAGE INFORMATION

APPLICANT

Do you currently have or have you had health insurance in the past 11 months? ☐ Yes ☐ No **(if no continue to Spouse/Dependent(s) section below)**

Has the coverage been continuous during the past 11 months? ☐ Yes ☐ No | Coverage start date (MMDDYYYY)

Will your current group insurance remain in effect after you enroll in this Empire plan? ☐ Yes ☐ No | Coverage end date (MMDDYYYY)

Name of other insurance carrier | Your ID no. from other carrier

Coverage provided by employer? ☐ Yes ☐ No | Employment status ☐ Active ☐ Retired

Contract type: ☐ Employee/Spouse ☐ Family ☐ Individual ☐ Parent/Child(ren)

Coverage type: ☐ Hospital only ☐ Hospital/Medical ☐ Medical only ☐ Other

SPOUSE/DEPENDENT(S)

Does your spouse/dependent(s) currently have or have they had health insurance in the past 11 months? ☐ Yes ☐ No **(if no continue to section 5)**

Has the coverage been continuous during the past 11 months? ☐ Yes ☐ No | Coverage start date (MMDDYYYY)

Will their current group insurance remain in effect after you enroll in this Empire plan? ☐ Yes ☐ No | Coverage start date (MMDDYYYY)

☐ My spouse has or has had the same coverage as I.
☐ My dependents have or have had the same coverage as I.

Note: You do not need to fill out the rest of the spousal other coverage questions.
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 | Employment status ☐ Active ☐ Retired

Contract type: ☐ Employee/Spouse ☐ Family ☐ Individual ☐ Parent/Child(ren)

Coverage type: ☐ Hospital only ☐ Hospital/Medical ☐ Medical only ☐ Other

DEPENDENT 1

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 ☐ Family ☐ Parent/Child(ren)	Coverage type:	☐ Hospital only ☐ Hospital/Medical ☐ Medical only ☐ Other

DEPENDENT 2

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 ☐ Family ☐ Parent/Child(ren)	Coverage type:	☐ Hospital only ☐ Hospital/Medical ☐ Medical only ☐ 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 ☐ Family ☐ Parent/Child(ren)	Coverage type:	☐ Hospital only ☐ Hospital/Medical ☐ Medical only ☐ 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:	☐ Employee/Spouse ☐ Individual ☐ Family ☐ Parent/Child(ren)	Coverage type:	☐ Hospital only ☐ Hospital/Medical ☐ Medical only ☐ Other

5. MEDICARE INFORMATION (FOR MEDICARE ELIGIBLE ONLY.)

Please provide a copy of your Medicare (HIB) card. If a copy is not attached, we cannot process your Medicare benefits request.

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.

Applicant last 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 SECTION MUST BE FILLED IN BY YOUR GROUP BENEFITS ADMINISTRATOR.)

Group name	Group no.	Group Sub no.
LEGAL SERVICES FOR NYC	2341577	

Address
40 WORTH STREET, SUITE 606

City	State	ZIP code
NEW YORK	NY	10013

Employee no.	Payroll/Department location	Applicant's start date of full-time employment

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	MONICA RAMIREZ	

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