Enrollment/Change Form

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.

Empire BlueCross BlueShield
An Anthem Company

Section 1: Reason for enrollment/change — Please complete section A, B or C.

A. New enrollment/addition — Choose only one reason in bold.

☐ **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)
☐ **Open enrollment** Leave *Date of change* field blank
☐ **Status change** – Select only one
☐ Marriage ☐ Newborn ☐ Adoption ☐ Retirement ☐ Medicare eligible For *Medicare eligible* only, answer the following questions:
Eligibility criteria – Select only one ..... ☐ Age 65+ ☐ Disability ☐ ESRD: Onset date: ____
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 endstage renal disease does not apply, you must choose this option)
☐ **Mandatory Right of Election – NYS Qualified dependents only.** Must complete section 3.
☐ **Original COBRA/NYS Continuation of coverage:** ____ (MM/DD/YY)
Nature of COBRA/NYS event: ____
☐ **Loss of Coverage** Must indicate last day covered in section 5.
☐ Other: ____

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

☐ Name ☐ Address ☐ Primary Care Physician (PCP) (HMO and POS plans only) ☐ Managed Dental Primary Care Dentist (PCD) (If your company offers an Empire Dental plan) Date of change: ____ (MM/DD/YY)

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.

Spouse/Dependent ☐ Death ☐ Divorce ☐ Dependent no longer eligible Date of event: ____ (MM/DD/YY)
☐ Other: ____

Section 2: Benefits Selection

Medical Insurance[1] Select only one plan type:

Large group plans (101+ eligibles)

The following plans are available prior to 7/1/17

☐ HMO
☐ HMO with Blue Priority network[2]
☐ Direct HMO
☐ EPO
☐ Empire Prism℠ EPO
☐ Empire Prism EPO with Blue Priority network[2]
☐ Empire Prism EPO Select
☐ Empire Total Blue EPO (HSA)
☐ Empire Total Blue EPO (HSA) with Blue Priority network[2]
☐ Empire Total Blue EPO (HRA)
☐ Empire Total Blue EPO (HRA) with Blue Priority Network[2]
☐ PPO
☐ Empire Prism℠ PPO
☐ Empire Total Blue PPO (HSA)
☐ Empire Total Blue PPO (HRA)
☐ Direct POS
☐ DS POS

The following plans are available 7/1/17

☐ Empire EPO (Copay Plan)
☐ Empire PPO (Copay Plan)
☐ Empire Blue Priority EPO (Copay)[2]
☐ Empire EPO (Copay + Coinsurance Plan)
☐ Empire PPO (Copay + Coinsurance Plan)
☐ Empire Blue Priority EPO (Copay + Coinsurance Plan)[2]
☒ Empire EPO (Copay + Deductible + Coinsurance Plan)
☐ Empire PPO (Copay + Deductible + Coinsurance Plan)
☐ Empire Blue Priority EPO (Copay + Deductible + Coinsurance Plan)[2]
☐ Empire EPO with HSA
☐ Empire EPO with HRA
☐ Empire PPO with HSA
☐ Empire PPO with HRA
☐ Empire Blue Priority EPO with HSA[2]
☐ Empire Blue Priority EPO with HRA[2]
☐ Empire EPO with HSA (HSA with Copay Plan)
☐ Empire EPO with HRA (HRA with Copay Plan)
☐ Empire Blue Priority EPO with HSA (HSA with Copay Plan)[2]
☐ Empire Blue Priority EPO with HRA (HRA with Copay Plan)[2]
☐ Empire EPO (Deductible + Coinsurance Plan)
☐ Empire PPO (Deductible + Coinsurance Plan)
☐ Empire Blue Priority EPO (Deductible + Coinsurance Plan)[2]

Other: Low Plan

Select only one medical coverage type: ☐ Individual ☐ Employee/Spouse/Domestic Partner ☐ 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.

Section 2: Benefits selection – Continued.

Dental Insurance [1]

☐ Empire Dental Prime
☐ Empire Dental Complete
☐ Empire Dental Premium Care (PPO)
☐ Empire Dental XPO
☐ Empire Dental Consumer Choice PPO
☐ Empire Dental Essential Choice PPO
☐ Empire Dental Enhanced Choice PPO
☐ Empire Dental Essential Care (managed care)
☐ Empire Dental Enhanced Care (managed care)
☐ Empire Dental Comprehensive Care (managed care)

Select only one dental coverage type: ☐ Individual ☐ Employee/Spouse/Domestic Partner ☐ Parent/Child(ren) ☐ Family

Vision Insurance [2] **Blue View Vision℠** Select only one coverage type: ☐ Individual ☐ Employee/Spouse/Domestic Partner ☐ Parent/Child(ren) ☐ Family

Flexible Spending Account (FSA)

☐ Healthcare FSA (excluded if you have an HSA plan)
☐ Dependent Care FSA
☐ Limited-Purpose FSA for dental and vision services only (with an HSA plan)
☐ Commuter Transit
☐ Commuter Parking

Section 3: Applicant information

Last name	First name	M.I.	Social Security no.[3] (required)

Sex ☐ Male ☐ Female	Date of birth (MM/DD/YY)	Marital status ☐ Single ☐ Married	Marriage date (MM/DD/YY)	Primary phone no.

Street address	Apt. no.

City	State	ZIP code

Occupation	Primary language

Email address[4]

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

Medicare Part D ID no.	Medicare Part D carrier	Part D effective date

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	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

1 If your company offers an Empire Dental Plan.
2 If your company offers a Blue View Vision plan.
3 Empire is required by the Internal Revenue Service to collect this information.
4 Email address is required for the applicant.

Section 4: Applicant and family information – Continued.

☐ **Spouse** ☐ **Domestic partner**

Last name	First name	M.I.	Social Security no.[1] (required)

Sex ☐ Male ☐ Female	Date of birth (MM/DD/YY)	Primary language, if different

PCP last name	PCP first name	PCP no.

Current patient of PCP? ☐ Yes ☐ No

PCD last name	PCD first name	PCD no.

Current patient of PCD? ☐ Yes ☐ No

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

Medicare Part D ID no.	Medicare Part D carrier	Part D effective date

Dependent 1

Last name	First name	M.I.	Social Security no.[1] (required)

Sex ☐ Male ☐ Female	Married? ☐ Yes ☐ No	Date of birth (MM/DD/YY)	Primary language, if different

PCP last name	PCP first name	PCP no.

Current patient of PCP? ☐ Yes ☐ No

PCD last name	PCD first name	PCD no.

Current patient of PCD? ☐ Yes ☐ No

Email address (requested for ages 18 and over): _____
☐ Yes, information may be sent to me electronically.

Relationship: ☐ Biological child of applicant/spouse/domestic partner ☐ Full-time student[2] ☐ Disabled child[3] ☐ Make available age 29 adult dependent child
☐ Other If other, what relationship? _____

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

Medicare Part D ID no.	Medicare Part D carrier	Part D effective date

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 4: Applicant and family information — Continued.

Dependent 2

Last name	First name	M.I.	Social Security no.[1] (required)

Sex ☐ Male ☐ Female	Married? ☐ Yes ☐ No	Date of birth (MM/DD/YY)	Primary language, if different

PCP last name	PCP first name	PCP no.

Current patient of PCP? ☐ Yes ☐ No

PCD last name	PCD first name	PCD no.

Current patient of PCD? ☐ Yes ☐ No

Email address (requested for ages 18 and over): _____
☐ Yes, information may be sent to me electronically.

Relationship: ☐ Biological child of applicant/spouse/domestic partner ☐ Full-time student[2] ☐ Disabled child[3] ☐ Make available age 29 adult dependent child
☐ Other If other, what relationship? _____

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

Medicare Part D ID no.	Medicare Part D carrier	Part D effective date

Dependent 3

Last name	First name	M.I.	Social Security no.[1] (required)

Sex ☐ Male ☐ Female	Married? ☐ Yes ☐ No	Date of birth (MM/DD/YY)	Primary language, if different

PCP last name	PCP first name	PCP no.

Current patient of PCP? ☐ Yes ☐ No

PCD last name	PCD first name	PCD no.

Current patient of PCD? ☐ Yes ☐ No

Email address (requested for ages 18 and over): _____
☐ Yes, information may be sent to me electronically.

Relationship: ☐ Biological child of applicant/spouse/domestic partner ☐ Full-time student[2] ☐ Disabled child[3] ☐ Make available age 29 adult dependent child
☐ Other If other, what relationship? _____

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

Medicare Part D ID no.	Medicare Part D carrier	Part D effective date

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 medical coverage information — This section must be completed.

Is anyone applying for coverage covered by other health coverage? ☐ Yes ☐ No **If yes, please complete the following:**

Name(s) of person(s) (first, M.I. last)	Insurance company name	Coverage dates	Provided by employer?	Employment status	Contract type
Self	Carrier name Policyholder name Phone Certificate (policy no.)	First day covered Last day covered	☐ Yes ☐ No	☐ COBRA/NYS Continuation of coverage ☐ Active ☐ Retiree	☐ Individual ☐ Family ☐ Employee/Spouse ☐ Parent/Child(ren)
☐ Spouse ☐ Domestic Partner	Carrier name Policyholder name Phone Certificate (policy no.)	First day covered Last day covered	☐ Yes ☐ No	☐ COBRA/NYS Continuation of coverage ☐ Active ☐ Retiree	☐ Individual ☐ Family ☐ Employee/Spouse ☐ Parent/Child(ren)
Dependent 1	Carrier name Policyholder name Phone Certificate (policy no.)	First day covered Last day covered	☐ Yes ☐ No	☐ COBRA/NYS Continuation of coverage ☐ Active ☐ Retiree	☐ Individual ☐ Family ☐ Employee/Spouse ☐ Parent/Child(ren)
Dependent 2	Carrier name Policyholder name Phone Certificate (policy no.)	First day covered Last day covered	☐ Yes ☐ No	☐ COBRA/NYS Continuation of coverage ☐ Active ☐ Retiree	☐ Individual ☐ Family ☐ Employee/Spouse ☐ Parent/Child(ren)
Dependent 3	Carrier name Policyholder name Phone Certificate (policy no.)	First day covered Last day covered	☐ Yes ☐ No	☐ COBRA/NYS Continuation of coverage ☐ Active ☐ Retiree	☐ Individual ☐ Family ☐ Employee/Spouse ☐ Parent/Child(ren)

Prior and other dental coverage information

Has any person applying for coverage had prior or other dental insurance coverage? ☐ Yes ☐ No

If yes, applicant/family member name(s): _____

Type of continuous coverage: ☐ Group ☐ Individual ☐ Other: _____

Carrier name: _____ Carrier phone no.: _____ Member ID: _____

Date coverage began: ____/____/____ Date ended: ____/____/____

Included orthodontia? ☐ Yes ☐ No

Section 6: Applicant signature — I have read the Certification, Insurance Fraud Statement and Electronic Notice 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.

Electronic Notice: I'm signing here because I want to get information about my benefits by email or electronically. This may include my certificate or evidence of coverage, explanation of benefits statements, required notices and helpful or personalized information to get the most out of my plan, so I will make sure Empire has my most up to date email. These electronic communications may include specific details about me and my plan. I know I can change my mind at any time or request a free copy of specific materials by mail. I'll just contact Empire to do either.

I certify each Social Security number submitted is correct.

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 X	Print name	Date (MM/DD/YY)

Section 7: Employer information — This section must be filled in by your group benefits administrator.

Group name	Group no.	Group sub no.
	300171	0002

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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