DUTCHESS EDUCATIONAL HEALTH INSURANCE CONSORTIUM

Employer Use Only

SECTION 1

Your Last Name | First | M.I | Your Social Security No. | Group Name

Address | ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐Domestic Partner | Group No. | Employee Code

City | State | Zip Code | Date of Marriage | Date Of Divorce | Effective Date Requested

Employment Status: ☐Full-time ☐Part-time ☐Active ☐Retired ☐COBRA

Date Of Employment | Date Of Retirement | Phone No.

R&K Use Only

Employee No.	Billing Class	Group Code

SECTION 2

☐ New Enrollment/Reinstatement (complete Section 4)

☐ Change Coverage to: (check new coverage)

☐ Cancel Coverage: (check those that apply)

☐ Add or Delete Dependent: (complete section 4)

☐ Severance Agreement In Place: Enter Severance Date:

Reason :

Group#		IND	2PER	FAM	MEDI
	Healthy Adv. PPO	☐	☐	☐	☐
	EPO - 20	☐	☐	☐	☐
	Alt PPO	☐	☐	☐	☐
	HMO	☐	☐	☐	☐
	Dental	☐	☐	☐	☐
	Vision	☐	☐	☐	☐

SECTION 3

Other Coverage?
Is there Coverage Under any other group health plan available to you or any member of your family
☐ **NO** ☐ **Yes**

If Yes; Policyholder Name | Relationship ☐ Self ☐Spouse ☐ Child

Insurance Company Name

Birthdate | Policy Number

Address

Plan Type: ☐Self only ☐Self and Family
Coverage Type: ☐Health ☐Drug ☐Dental ☐Vision

SECTION 4

LIST APPLICANT AND ALL ELIGIBLE DEPENDENTS

COPY OF MEDICARE CARD REQUIRED

ADD	DEL	RELATION-SHIP	NAME (LAST FIRST M.I.)	Birthdate (mo/day/yr)	Social Security #	Medicare A&B Effective Date
☐	☐	☐M ☐F	SELF		xxx-xx-xxxx	A B
☐	☐	☐ Husband ☐ Wife ☐ Domestic Partner				A B
☐	☐	☐ Son ☐Daughter				A B
☐	☐	☐ Son ☐Daughter				A B
☐	☐	☐ Son ☐Daughter				A B
☐	☐	☐ Son ☐Daughter				A B

SECT. 5

Do your dependents reside in your home?

☐Yes ☐No If no give address

Please provide name(s) and address:

Do you have a disabled dependent beyond age 19?
☐No ☐ Yes If yes list name(s)

Applicant's Signature: Date: | Adult Dependent Signature: Date: |Employer's Signature:

GENERAL AUTHORIZATION

All information furnished hereon is true and complete to the best of my knowledge. 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 also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation. I hereby authorize my employer to make any required payroll deductions.

ADDITIONAL AUTHORIZATION FOR APPLICANTS

For Empire EPO/PPO:

BASIC COVERAGE AGREEMENT:

I certify that I am an employee or dependent of an employee of the group, a retiree of the group or a former qualified group member who is electing continuation of coverage under COBRA or New York State Continuation of coverage legislation. I hereby elect the coverage offered by my group of the type checked. If this election form is for a family or husband/wife or parent/child(ren) contract, the name of my spouse and unmarried eligible dependent children are listed, I make this request on their behalf as well as my own. I understand that I am under a continuing obligation to notify the group of a change in my or my dependents' status. That such a 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 issued by Empire.

I authorize any health care provider, payor of health and health related claims, government agency or dentist to furnish to Empire or its designee all records pertaining to medical history, services rendered, and payments made regarding me or my dependents for review and evaluation of any claim, or services in conjunction with managed care. I also authorize Empire to disclose such information to my PCP and other network physician(s), to another payer of self-insurer and to the group contract holder or any Empire designee for purposes of continuity of care and medical management, disease management, managed disability coordination or financial audits. This authorization shall become effective immediately, and shall remain in effect for six years after the termination of coverage, or the last determination or payment by Empire on a claim or service under the coverage, whichever is latest. This authorization shall be binding upon me, my dependents, my heirs, executors, or administrators.

MEDICARE-RELATED COVERAGE AGREEMENT:

Medicare-related or Carveout coverage will be issued, as appropriate depending on the terms of your coverage, to persons eligible for Medicare when the group notifies Empire that an individual is no longer eligible for primary coverage under the group's health benefits plan. Medicare-related coverage is designed to supplement Medicare by covering some hospital, medical, surgical services partially covered by Medicare. Carveout coverage provides the group's benefits, less the benefits available from Medicare.

For Capital District Physicians' Health Plan:

I hereby authorize any person or institution who shall have rendered services to me or to any member of my family unit under THE CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN contract to make available to THE CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN to such an extent as may be reasonable, any photographs, records, or information regarding such services, requested by THE CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN, which shall be kept confidential by THE CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN. I understand that unresolved grievances are subject to the procedure specified in the group contract. This authorization to disclose medical information shall remain in effect until revoked by me in writing.

On behalf of myself and any dependents listed, I hereby apply for coverage under the Master Group Contract issued to my employer by THE CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN. I understand that the benefits for which I (we) will be eligible are in accordance with those described in the Master Group Contract and any changes provided for therein. I further understand that except for emergencies, covered services must be obtained through a participating physician, and also that certain services may require a copayment by me (or my dependents) directly to the provider of such services.

For GHI HMO:

I agree to choose a participating GHI HMO physician for primary care. I understand that prior approval from my GHI HMO primary care physician is required for all care except life threatening emergencies. By signing this enrollment form, you automatically authorize release of your medical records for the following purposes: (1) Internal use by GHI HMO for bonafide medical purposes for compilation of demographic data; (2) for internal and external audits or for use in the administration of the member contract; (3) to comply with government requirements established by law; or if the information is the subject of a court order which mandates its disclosure.

For MVP Health Plan:

I CERTIFY that I am familiar with my contract with MVP, and that I agree to abide to the terms therein.

I AUTHORIZE any licensed physician, hospital, or other health care provider to furnish MVP with such medical information about myself and eligible dependents listed on the application that may be required.

I UNDERSTAND and agree that (with the exception of emergency procedures) all services, in order to be covered by MVP, must be performed either by a Participating Primary Care Physician or authorized by prior referral from a Participating Primary Care Physician.

I AGREE to make directly to providers of health care such co-payments as are provided for in the contract with MVP.

I HEREBY AGREE TO THE ABOVE CONDITIONS OF ENROLLMENT AND APPLY FOR MEMBERSHIP IN MVP.