



## I. SUBSCRIBER INFORMATION

Last Name		First Name		M.I.	Sex	Social Security Number					
Street Address		Apt.	City			State	ZIP Code				
<b>Were you ever a member of EmblemHealth?</b> <input type="checkbox"/> NO <input type="checkbox"/> YES If YES, member ID _____		<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner		<b>Birth Date:</b> Mo.   Day   Yr.		Telephone #: Home: (____) _____ Work: (____) _____		E-Mail Address: _____ <input type="checkbox"/> <b>"GO PAPERLESS" and save trees (see back of application)*</b>			
Young Adult Coverage: <input type="checkbox"/> 26 And Under — Family <input type="checkbox"/> 26 - 29 — Single    Parent ID: _____						Subscriber Employment Status: _____ <input type="checkbox"/> Applicant working at least 20 hours per week					
<b>Disabled?</b> <input type="checkbox"/> NO <input type="checkbox"/> YES		<b>Primary Care Physician Name:</b> (Not required for EPO/PPO members) ID Number: _____				<b>OB/GYN Selection Name:</b> (Optional) ID Number: _____					
<b>Prior Health Insurance Information:</b> Carrier Name: _____ Coverage Begin Date: ___/___/___ Coverage End Date: ___/___/___		<b>Are you covered by any other health insurance or Medicare?</b> <input type="checkbox"/> NO <input type="checkbox"/> YES If YES, indicate: Insurance Co. Name: _____ Insurance Co. Telephone #: (____) _____ Type of Coverage: _____ Policy #: _____ Effective Date: ___/___/___				<b>Check One:</b> <input type="checkbox"/> New Enrollment <input type="checkbox"/> Reinstatement <input type="checkbox"/> Termination <input type="checkbox"/> Change to Ind.		<b>Status:</b> <input type="checkbox"/> Add Dependent <input type="checkbox"/> Remove Dep. <input type="checkbox"/> Address Change <input type="checkbox"/> Name Change		<b>Transfer:</b> <input type="checkbox"/> To Another Carrier <input type="checkbox"/> EmblemHealth Group Change: From: _____ To: _____	

## II. ENROLLMENT INFORMATION — IF YOU ARE ENROLLING YOUR SPOUSE/DP AND/OR CHILDREN, PLEASE LIST EACH ONE BELOW — SEE ELECTION OF COVERAGE FOR ELIGIBILITY

Last Name (if different)	First Name	Social Security Number	Sex	Relationship	Birth Date			✓ if Disabled	Primary Care Physician Name/ID Number <small>(Not required for EPO/PPO members)</small>	OB/GYN Selection Name/ID Number <small>(Optional)</small>
					Mo.	Day	Yr.			
DEPENDENT				<input type="checkbox"/> Spouse <input type="checkbox"/> DP <input type="checkbox"/> Child						
Current/Prior Health Insurance Information:    Carrier Name: _____    Coverage Begin Date: ___/___/___    Coverage End Date: ___/___/___										
DEPENDENT				<input type="checkbox"/> Child						
Current/Prior Health Insurance Information:    Carrier Name: _____    Coverage Begin Date: ___/___/___    Coverage End Date: ___/___/___										
DEPENDENT				<input type="checkbox"/> Child						
Current/Prior Health Insurance Information:    Carrier Name: _____    Coverage Begin Date: ___/___/___    Coverage End Date: ___/___/___										

**Note:** A birth/marriage certificate or 1040 Form will be required for spouse/dependents with different last name.

**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:** \_\_\_/\_\_\_/\_\_\_

## III. EMPLOYER INFORMATION — THIS SECTION TO BE COMPLETED BY EMPLOYER/CONTRACTOR GROUP

Name of Group:		Group Number:		<input type="checkbox"/> EmblemHealth <input type="checkbox"/> GHI <input type="checkbox"/> GHI HMO <input type="checkbox"/> HIP Plan Name: _____		<b>Type of Coverage:</b> <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Employee & Spouse/DP <input type="checkbox"/> Employee & Child			
Requested Effective Date: Medical: ___/___/___    Dental: ___/___/___		Hire Date:		Waiting Period:		Date Submitted:		Approved By: (Group Plan Administrator)	

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

# ELECTION OF COVERAGE

Pre-existing conditions will not be covered during the first 12 months of enrollment in the EmblemHealth CompreHealth program or during the first 11 months of enrollment in the EmblemHealth EPO, EmblemHealth PPO, EmblemHealth ConsumerDirect PPO or EmblemHealth ConsumerDirect EPO plans. For policies issued or renewed after September 23, 2010, pre-existing condition limitations will be waived for enrollees under age 19. A pre-existing condition is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice of treatment was recommended or received during the six-month period prior to your enrollment date. EmblemHealth will credit the time you were covered by prior creditable health insurance coverage toward the 12-month or 11-month period, as long as the break in coverage between the prior coverage and your EmblemHealth coverage does not exceed 63 days, exclusive of any waiting periods. If requested, you or your group must provide EmblemHealth with information about your pre-existing conditions and/or previous coverage. You have the right to request a Certificate of Creditable Coverage from your prior health plan. If needed, EmblemHealth will help you get such a certificate from your prior plan.

A large group (51 or more eligible employees) may elect to cover pre-existing conditions from the start of your EmblemHealth coverage. In such a case, your EmblemHealth policy will not contain a pre-existing condition limitation or it will state that the pre-existing condition limitation does not apply.

Please call EmblemHealth at 1-877-842-3625 for more information about a pre-existing condition limitation.

## IMPORTANT INFORMATION

1. The subscriber must complete sections I and II. The group plan administrator must complete section III and if for a small group (50 employees or fewer), provide all necessary documentation.
2. All transactions are subject to EmblemHealth's retroactive policy (30 days for small groups, 90 days for large groups).
3. For policies issued or renewed after September 23, 2010, dependent children may stay on or be added to a parent's policy until age 26 (end of birthday month), regardless of student status, as part of federal health reform. The premium will be billed at the applicable coverage tier and, other than the basic enrollment form, nothing else is required. Most employer groups cannot limit dependent coverage eligibility even if the qualified dependent has access to his or her own employer-based coverage. Only standard GHI and HIP HMO Direct Pay, Healthy New York and GHI large groups have the possibility of restrictions for adding dependents up to age 26. As part of New York State's "age 29" law, eligible young adults through age 29 (up to 30th birthday) may continue or obtain coverage through a parent's group policy.
4. Failure to complete any part of this form (e.g., group number, reason for submission, certificate number, signature, etc.) will require EmblemHealth to return this transaction form to the employer group plan administrator and may delay the requested effective date of coverage.

Effective September 23, 2010, federal health reform may require changes to your coverage, depending on your plan. Get more information at [www.emblemhealthreform.com](http://www.emblemhealthreform.com).

\* By electing "Go Paperless," you will receive claim statements and some other EmblemHealth letters by e-mail instead of paper mail. You will be able to view your Explanation of Benefits (EOBs) under the Claims section of the EmblemHealth Web site. Your enrollment in the "Go Paperless" option will continue as long as your account remains active, or until you choose to discontinue this option.

SECTION A (To be completed by Benefits Administrator)		DOCUMENTATION BASED ON GROUP SIZE			
		Group Type (Check One) 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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
<input type="checkbox"/> 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 provide copy of payroll documentation reflecting the date, employee's name and Social Security #, or the employee's current-year W4 form.	Not Eligible		
<input type="checkbox"/> Add Spouse	Marriage	<b>If last name is different</b> <input type="checkbox"/> Marriage Certificate <input type="checkbox"/> 1040 Form			
<input type="checkbox"/> Add Dependent	Birth Adoption	<b>If last name is different</b> <input type="checkbox"/> Birth Certificate <input type="checkbox"/> Formal Adoption Papers <input type="checkbox"/> Court Approved Guardianship Papers			
<input type="checkbox"/> Add Spouse <input type="checkbox"/> Add Dependent	Loss of Coverage	Certificate of Creditable Coverage			
<input type="checkbox"/> Add Domestic Partner	Domestic Partnership	Declaration of Cohabitation & Financial Interdependence form	Not Eligible	Not Eligible	

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

**Effective September 23, 2010, federal health reform may require changes to your coverage, depending on your plan. Get more information at [www.emblemhealthreform.com](http://www.emblemhealthreform.com).**