

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.



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

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

- | | | |
|---|--|---|
| <input type="checkbox"/> HMO | <input type="checkbox"/> Empire Total Blue EPO (HSA) | <input type="checkbox"/> PPO |
| <input type="checkbox"/> HMO with Blue Priority network ² | <input type="checkbox"/> Empire Total Blue EPO (HSA) with Blue Priority network ² | <input type="checkbox"/> Empire Prism SM PPO |
| <input type="checkbox"/> Direct HMO | <input type="checkbox"/> Empire Total Blue EPO (HRA) | <input type="checkbox"/> Empire Total Blue PPO (HSA) |
| <input type="checkbox"/> EPO | <input type="checkbox"/> Empire Total Blue EPO (HRA) with Blue Priority Network ² | <input type="checkbox"/> Empire Total Blue PPO (HRA) |
| <input type="checkbox"/> Empire Prism SM EPO | | <input type="checkbox"/> Direct POS |
| <input type="checkbox"/> Empire Prism EPO with Blue Priority network ² | | <input type="checkbox"/> DS POS |
| <input type="checkbox"/> Empire Prism EPO Select | | |

The following plans are available 7/1/17

- | | |
|--|--|
| <input type="checkbox"/> Empire EPO (Copay Plan) | <input type="checkbox"/> Empire PPO with HSA |
| <input type="checkbox"/> Empire PPO (Copay Plan) | <input type="checkbox"/> Empire PPO with HRA |
| <input type="checkbox"/> Empire Blue Priority EPO (Copay) ² | <input type="checkbox"/> Empire Blue Priority EPO with HSA ² |
| <input type="checkbox"/> Empire EPO (Copay + Coinsurance Plan) | <input type="checkbox"/> Empire Blue Priority EPO with HRA ² |
| <input type="checkbox"/> Empire PPO (Copay + Coinsurance Plan) | <input type="checkbox"/> Empire EPO with HSA (HSA with Copay Plan) |
| <input type="checkbox"/> Empire Blue Priority EPO (Copay + Coinsurance Plan) ² | <input type="checkbox"/> Empire EPO with HRA (HRA with Copay Plan) |
| <input type="checkbox"/> Empire EPO (Copay + Deductible + Coinsurance Plan) | <input type="checkbox"/> Empire Blue Priority EPO with HSA (HSA with Copay Plan) ² |
| <input type="checkbox"/> Empire PPO (Copay + Deductible + Coinsurance Plan) | <input type="checkbox"/> Empire Blue Priority EPO with HRA (HRA with Copay Plan) ² |
| <input type="checkbox"/> Empire Blue Priority EPO (Copay + Deductible + Coinsurance Plan) ² | <input type="checkbox"/> Empire EPO (Deductible + Coinsurance Plan) |
| <input type="checkbox"/> Empire EPO with HSA | <input type="checkbox"/> Empire PPO (Deductible + Coinsurance Plan) |
| <input type="checkbox"/> Empire EPO with HRA | <input type="checkbox"/> Empire Blue Priority EPO (Deductible + Coinsurance Plan) ² |

Other: _____

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 Insurance¹**

- | | | |
|---|---|--|
| <input type="checkbox"/> Empire Dental Prime | <input type="checkbox"/> Empire Dental Consumer Choice PPO | <input type="checkbox"/> Empire Dental Essential Care (managed care) |
| <input type="checkbox"/> Empire Dental Complete | <input type="checkbox"/> Empire Dental Essential Choice PPO | <input type="checkbox"/> Empire Dental Enhanced Care (managed care) |
| <input type="checkbox"/> Empire Dental Premium Care (PPO) | <input type="checkbox"/> Empire Dental Enhanced Choice PPO | <input type="checkbox"/> Empire Dental Comprehensive Care (managed care) |
| <input type="checkbox"/> Empire Dental XPO | | |

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

Vision Insurance² Blue View VisionSM Select only one coverage type: Individual Employee/Spouse/Domestic Partner Parent/Child(ren) Family

Flexible Spending Account (FSA)

- | | | |
|--|---|---|
| <input type="checkbox"/> Healthcare FSA (excluded if you have an HSA plan) | <input type="checkbox"/> Limited-Purpose FSA for dental and vision services only (with an HSA plan) | <input type="checkbox"/> Commuter Transit |
| <input type="checkbox"/> Dependent Care FSA | | <input type="checkbox"/> Commuter Parking |

Section 3: Applicant information

Last name		First name		M.I.	Social Security no. ³ (required)	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (MM/DD/YY)	Marital status <input type="checkbox"/> Single <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Primary care dentist (PCD) last name	PCD first name	PCD no.
Current patient of PCD? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (MM/DD/YY)	Primary language, if different			
PCP last name		PCP first name		PCP no.	
Current patient of PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No					
PCD last name		PCD first name		PCD no.	
Current patient of PCD? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Email address (requested for ages 18 and over): _____ <input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Married? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of birth (MM/DD/YY)	Primary language, if different		
PCP last name		PCP first name		PCP no.	
Current patient of PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No					
PCD last name		PCD first name		PCD no.	
Current patient of PCD? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Email address (requested for ages 18 and over): _____ <input type="checkbox"/> Yes, information may be sent to me electronically.					
Relationship: <input type="checkbox"/> Biological child of applicant/spouse/domestic partner <input type="checkbox"/> Full-time student ² <input type="checkbox"/> Disabled child ³ <input type="checkbox"/> Make available age 29 <u>adult</u> dependent child <input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Married? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of birth (MM/DD/YY)	Primary language, if different		
PCP last name		PCP first name		PCP no.	
Current patient of PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No					
PCD last name		PCD first name		PCD no.	
Current patient of PCD? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Email address (requested for ages 18 and over): _____ <input type="checkbox"/> Yes, information may be sent to me electronically.					
Relationship: <input type="checkbox"/> Biological child of applicant/spouse/domestic partner <input type="checkbox"/> Full-time student ² <input type="checkbox"/> Disabled child ³ <input type="checkbox"/> Make available age 29 <u>adult</u> dependent child <input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Married? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of birth (MM/DD/YY)	Primary language, if different		
PCP last name		PCP first name		PCP no.	
Current patient of PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No					
PCD last name		PCD first name		PCD no.	
Current patient of PCD? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Email address (requested for ages 18 and over): _____ <input type="checkbox"/> Yes, information may be sent to me electronically.					
Relationship: <input type="checkbox"/> Biological child of applicant/spouse/domestic partner <input type="checkbox"/> Full-time student ² <input type="checkbox"/> Disabled child ³ <input type="checkbox"/> Make available age 29 <u>adult</u> dependent child <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> COBRA/NYS Continuation of coverage <input type="checkbox"/> Active <input type="checkbox"/> Retiree	<input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Parent/Child(ren)
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	Carrier name Policyholder name Phone Certificate (policy no.)	First day covered Last day covered	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> COBRA/NYS Continuation of coverage <input type="checkbox"/> Active <input type="checkbox"/> Retiree	<input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Parent/Child(ren)
Dependent 1	Carrier name Policyholder name Phone Certificate (policy no.)	First day covered Last day covered	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> COBRA/NYS Continuation of coverage <input type="checkbox"/> Active <input type="checkbox"/> Retiree	<input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Parent/Child(ren)
Dependent 2	Carrier name Policyholder name Phone Certificate (policy no.)	First day covered Last day covered	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> COBRA/NYS Continuation of coverage <input type="checkbox"/> Active <input type="checkbox"/> Retiree	<input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Parent/Child(ren)
Dependent 3	Carrier name Policyholder name Phone Certificate (policy no.)	First day covered Last day covered	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> COBRA/NYS Continuation of coverage <input type="checkbox"/> Active <input type="checkbox"/> Retiree	<input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> 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)
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Section 7: Employer information — This section must be filled in by your group benefits administrator.

Group name		Group no.	Group sub no.
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)	