



PO Box 80, Buffalo, NY 14240-0080

Enrollment Application/Change Form — SMALL

1—Group Employer Information. This section should be completed by the Group Benefits Administrator. This application cannot be processed without this information and a signature. Please use blue or black ink, print one character per box.

Subscriber Status: Active Retired COBRA
Group # Subgroup # Class #
Employer Name
Association/Chamber Name (if applicable)
Group Administrator Signature / Date

Please indicate reason for COBRA:
Left Employ / Retirement
Divorce/Legal Separation
Loss of Student Status
Death of Spouse
Dependent Reached Max Age
Other
Effective Date (MMDDYY)
COBRA Effective Date (MMDDYY)
Hire/Rehire Date (MMDDYY)
Retired Effective Date (MMDDYY)

2—Subscriber Plan Section Please use blue or black ink, print one character per box. Check applicable plan(s).

Plan Number:
Please indicate copay: PCP \$ Specialist \$
Single or Family:
POS POS Plus Dental HMO HMO Plus
PPO Traditional Vision EPO Aqua Other
Please choose coverage type: Medical Dental Vision S F

A. Have you obtained stand-alone dental coverage that provides a pediatric dental essential health benefit through a New York Health Benefit Exchange-certified stand-alone dental plan offered outside the New York Health Benefit Exchange?
B. If you answered "yes", please provide the name of the company issuing the stand-alone dental coverage.

If you answered "no", we will provide coverage of the pediatric dental essential health benefit.

3—Reason for Enrollment/Change - Subscriber, please indicate the reason for this enrollment or change.

New Hire COBRA Primary Care Physician Remove Dependent Loss of Coverage
Open Enrollment Address/Phone Number Last Name Retirement
Add Dependent Please indicate reason for adding dependent: Newborn Marriage Loss of Coverage
Adoption Domestic Partner Change in Student Status

4—Subscriber Information

Please complete both sides of this application. The subscriber signature is required in order to process the application.

Subscriber's Last Name Subscriber's First Name M.I.
Social Security Number Date of Birth (MMDDYY) Telephone Number (include area code) Gender: Female Male
Mailing Address Apt Suite Marital Status Single Married Divorced Legally Separated Widowed
City State Zip Code
E-mail Address Marital Status Event Date (MMDDYY)

Medicare Eligible Please indicate reason for Medicare eligibility: Age 65+ Disability End Stage Renal Disease
Medicare Number (if applicable) Part A Effective Date (MMDDYY) Part B Effective Date (MMDDYY) Part D Effective Date (MMDDYY)



4—Subscriber Information continued

Primary Care Physician's Last Name

[Redacted input field]

Primary Care Physician's First Name

[Redacted input field]

Primary Care Physician Number: Are you a current patient, or if not a current patient, have you verified that the PCP will accept you as a new patient?  Yes  No

[Redacted input field]

Do you have additional group health insurance?  Yes  No

Name of Prior Health Care Insurer

[Redacted input field]

Policy Identification Number

[Redacted input field]

Policy Effective Date (MMDDYY)

[Redacted input field]

Policy Cancellation Date (MMDDYY)

[Redacted input field]

5—Dependent Information Please provide all information for each person to be covered.

Spouse/Domestic Partner's Last Name

[Redacted input field]

Spouse/Domestic Partner's First Name

[Redacted input field]

M.I.

[Redacted input field]

Social Security Number

[Redacted input field]

Date of Birth (MMDDYY)

[Redacted input field]

Gender:  Female  Male

Are you enrolling as a Domestic Partner?  Yes  No

E-mail Address

[Redacted input field]

Medicare Eligible Please indicate reason for Medicare eligibility:  Age 65+  Disability  End Stage Renal Disease

Medicare Number (if applicable)

[Redacted input field]

Part A Effective Date (MMDDYY)

[Redacted input field]

Part B Effective Date (MMDDYY)

[Redacted input field]

Part D Effective Date (MMDDYY)

[Redacted input field]

Primary Care Physician's Last Name

[Redacted input field]

Primary Care Physician's First Name

[Redacted input field]

Primary Care Physician Number: Are you a current patient, or if not a current patient, have you verified that the PCP will accept you as a new patient?  Yes  No

[Redacted input field]

Do you have additional group health insurance?  Yes  No

Name of Prior Health Care Insurer

[Redacted input field]

Policy Identification Number

[Redacted input field]

Policy Effective Date (MMDDYY)

[Redacted input field]

Policy Cancellation Date (MMDDYY)

[Redacted input field]

Dependent's Last Name

[Redacted input field]

Dependent's First Name

[Redacted input field]

M.I.

[Redacted input field]

Social Security Number

[Redacted input field]

Date of Birth (MMDDYY)

[Redacted input field]

Gender:  Female  Male

Is your over-age dependent handicapped?  Yes  No

E-mail Address

[Redacted input field]

Medicare Eligible Please indicate reason for Medicare eligibility:  Age 65+  Disability  End Stage Renal Disease

Medicare Number (if applicable)

[Redacted input field]

Part A Effective Date (MMDDYY)

[Redacted input field]

Part B Effective Date (MMDDYY)

[Redacted input field]

Part D Effective Date (MMDDYY)

[Redacted input field]

Is dependent a full-time student?  Yes  No

If yes, please indicate college/university name:

College/University Name

[Redacted input field]

Expected Graduation Date (MMDDYY)

[Redacted input field]

Primary Care Physician's Last Name

[Redacted input field]

Primary Care Physician's First Name

[Redacted input field]

Primary Care Physician Number: Are you a current patient, or if not a current patient, have you verified that the PCP will accept you as a new patient?  Yes  No

[Redacted input field]

Do you have additional group health insurance?  Yes  No

If you answered "yes" to the question about stand-alone dental coverage in section 2, please provide the name of the company issuing the coverage.

[Redacted input field]

If you answered "no", we will provide coverage of the pediatric dental essential health benefit.

5—Dependent Information continued

Please provide all information for each person to be covered.

Subscriber's Last Name [ ] Subscriber's First Name [ ] M.I. [ ]

Social Security Number [ ] - [ ] - [ ] Date of Birth (MMDDYY) [ ]

Dependent's Last Name [ ] Dependent's First Name [ ] M.I. [ ]

Social Security Number [ ] - [ ] - [ ] Date of Birth (MMDDYY) [ ] Gender: [ ] Female [ ] Male Is your over-age dependent handicapped? [ ] Yes [ ] No

E-mail Address [ ]

[ ] Medicare Eligible Please indicate reason for Medicare eligibility: [ ] Age 65+ [ ] Disability [ ] End Stage Renal Disease

Medicare Number (if applicable) [ ] Part A Effective Date (MMDDYY) [ ] Part B Effective Date (MMDDYY) [ ] Part D Effective Date (MMDDYY) [ ]

Is dependent a full-time student? [ ] Yes [ ] No If yes, please indicate college/university name:

College/University Name [ ] Expected Graduation Date (MMDDYY) [ ]

Primary Care Physician's Last Name [ ] Primary Care Physician's First Name [ ]

Primary Care Physician Number: Are you a current patient, or if not a current patient, have you verified that the PCP will accept you as a new patient? [ ] Yes [ ] No

[ ] Do you have additional group health insurance? [ ] Yes [ ] No

If you answered "yes" to the question about stand-alone dental coverage in section 2, please provide the name of the company issuing the coverage. [ ]

If you answered "no", we will provide coverage of the pediatric dental essential health benefit.

Dependent's Last Name [ ] Dependent's First Name [ ] M.I. [ ]

Social Security Number [ ] - [ ] - [ ] Date of Birth (MMDDYY) [ ]

Gender: [ ] Female [ ] Male Is your over-age dependent handicapped? [ ] Yes [ ] No

E-mail Address [ ]

[ ] Medicare Eligible Please indicate reason for Medicare eligibility: [ ] Age 65+ [ ] Disability [ ] End Stage Renal Disease

Medicare Number (if applicable) [ ] Part A Effective Date (MMDDYY) [ ] Part B Effective Date (MMDDYY) [ ] Part D Effective Date (MMDDYY) [ ]

Is dependent a full-time student? [ ] Yes [ ] No If yes, please indicate college/university name:

College/University Name [ ] Expected Graduation Date (MMDDYY) [ ]

Primary Care Physician's Last Name [ ] Primary Care Physician's First Name [ ]

Primary Care Physician Number: Are you a current patient, or if not a current patient, have you verified that the PCP will accept you as a new patient? [ ] Yes [ ] No

[ ] Do you have additional group health insurance? [ ] Yes [ ] No

If you answered "yes" to the question about stand-alone dental coverage in section 2, please provide the name of the company issuing the coverage. [ ]

If you answered "no", we will provide coverage of the pediatric dental essential health benefit.



5—Dependent Information continued

Please provide all information for each person to be covered.

Dependent's Last Name \_\_\_\_\_ Dependent's First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Form boxes for last name, first name, and middle initial.

Social Security Number \_\_\_\_\_ Date of Birth (MMDDYY) \_\_\_\_\_ Gender:  Female  Male  
Is your over-age dependent handicapped?  Yes  No

E-mail Address \_\_\_\_\_

Medicare Eligible Please indicate reason for Medicare eligibility:  Age 65+  Disability  End Stage Renal Disease

Medicare Number (if applicable) \_\_\_\_\_ Part A Effective Date (MMDDYY) \_\_\_\_\_ Part B Effective Date (MMDDYY) \_\_\_\_\_ Part D Effective Date (MMDDYY) \_\_\_\_\_

Form boxes for Medicare number and effective dates.

Is dependent a full-time student?  Yes  No If yes, please indicate college/university name: \_\_\_\_\_

College/University Name \_\_\_\_\_ Expected Graduation Date (MMDDYY) \_\_\_\_\_

Form boxes for college name and graduation date.

Primary Care Physician's Last Name \_\_\_\_\_ Primary Care Physician's First Name \_\_\_\_\_

Form boxes for primary care physician's name.

Primary Care Physician Number: Are you a current patient, or if not a current patient, have you verified that the PCP will accept you as a new patient?  Yes  No

Form box for primary care physician number.

Do you have additional group health insurance?  Yes  No

If you answered "yes" to the question about stand-alone dental coverage in section 2, please provide the name of the company issuing the coverage.

Form box for dental coverage company name.

If you answered "no", we will provide coverage of the pediatric dental essential health benefit.

HMO/POS Coverage

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
• Surgery and reconstruction of the other breast to produce a symmetrical appearance;
• Prostheses; and;
• Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, call your Plan Administrator.

6—Disclosure / Signature

Subscriber signature required.

I AUTHORIZE ANY LICENSED DOCTOR, HOSPITAL OR OTHER HEALTH CARE PROVIDER TO PROVIDE MY PLAN WITH ANY INFORMATION REQUESTED CONCERNING MEDICAL SERVICES I OR MEMBERS OF MY FAMILY HAVE RECEIVED, WHICH THE PLAN DETERMINES IS NECESSARY FOR THE OPERATION AND REGULATION OF THE PLAN. THIS INFORMATION WILL BE KEPT CONFIDENTIAL AND IS VALID FOR UP TO 24 MONTHS.

Important: Please read and sign below:

\* 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 CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.



Subscriber Signature \_\_\_\_\_

Date \_\_\_\_\_