



ENROLLMENT/CHANGE FORM

Thank you for choosing Empire. Please fill out all items in order for us to quickly and accurately process your enrollment. Make sure you use **blue or black ink only, fill in circles completely, print in capital letters, and stay within the boxes when writing.** Once you've completed this form, please sign in the space provided in Section 7.

PO Box 1407, Church Street Station, New York, NY 10008-1407
www.empireblue.com

1. REASON FOR ENROLLMENT/CHANGE Complete section A, B or C.

A. New Enrollment/Addition (fill in one circle only)

- New Hire** Proof of employment is necessary for applicants in companies with 50 or fewer employees. Please submit NYS-45, payroll records or W-4 forms to establish employment.
- Open Enrollment** **Date of Change (MMDDYY)**

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- Status Change** (fill in one circle below)
 - Marriage Newborn Adoption Retirement
 - Medicare Eligible (answer questions below)
 - Eligibility criteria (fill in one circle only) Age 65+ Disability End Stage Renal Disease
 - 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 end stage renal disease does not apply, you must choose this option)
 - Part-Time to Full-Time
 - COBRA/NYS Continuation of Coverage
 - Nature of COBRA/NYS Event:
 - Other:

B. Change (fill in all circles that apply)

- For all circles filled in below, please supply new information in Section 3.
- Name Address
 - HMO/Direct HMO/POS/DSPOS Primary Care Physician (PCP)
 - Managed Dental Primary Care Dentist (PCD)
If your company offers an Empire Dental plan

C. Cancel Coverage (fill in one circle only)

Note: If you are canceling your own coverage, please have your employer fill out an Employee Termination Form. For other cancellations, please fill in the appropriate circle below and enter the name in the Spouse/Dependent portion in Section 3.

Spouse/Dependent

- Death Divorce
- Dependent no longer eligible
- Other:

Date of Event (MMDDYY)

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2. BENEFITS SELECTION

- Medical Insurance** (fill in one circle only) PPO EPO HMO Direct HMO Indemnity: Hospital/Medical **or** Hospital Only Other
- DPOS DSPOS Value EPO (small group only) Empire Total BlueSM Choice (HSA)[†] Empire Total BlueSM Choice (HRA)
- Empire PrismSM PPO (large group only) Empire PrismSM EPO

- Coverage Type** (fill in one circle only) Individual Employee/Spouse Parent/Child(ren) Family

- Dental Insurance**[‡] (fill in one circle only) PPO Dental Managed Dental Voluntary Dental Other Dental

- Coverage Type** (fill in one circle only) Individual Employee/Spouse Parent/Child(ren) Family

[†] Empire will facilitate the opening of a Health Savings Account in your name, as directed by your Employer.

[‡] If your company offers an Empire Dental plan

3. APPLICANT AND SPOUSE/DEPENDENT INFORMATION

Note: If you've chosen HMO/Direct HMO/POS/DSPOS, 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/Direct HMO members except for emergency care. If you've chosen Managed Dental, please provide one Primary Care Dentist (PCD) for you and your dependents.

Last Name	First Name	MI
<table border="1" style="border-collapse: collapse; width: 100%; height: 20px;"></table>	<table border="1" style="border-collapse: collapse; width: 100%; height: 20px;"></table>	<table border="1" style="border-collapse: collapse; width: 100%; height: 20px;"></table>
Social Security Number	Gender	Birth Date (MMDDYY)
<table border="1" style="border-collapse: collapse; width: 100%; height: 20px;"></table>	<input type="radio"/> M <input type="radio"/> F	<table border="1" style="border-collapse: collapse; width: 100%; height: 20px;"></table>
	Marital Status	Date of Marriage (MMDDYY)
	<input type="radio"/> Married <input type="radio"/> Single	<table border="1" style="border-collapse: collapse; width: 100%; height: 20px;"></table>

Applicant

+

3. APPLICANT AND SPOUSE/DEPENDENT INFORMATION (continued)

Applicant (cont.)

Home Phone

Daytime Phone

Home Address

Apt. No.

City

State

Zip

Occupation

Primary Language

PCP Last Name

PCP First Name

PCP Number

Current Patient of PCP?

 Y N

Primary Care Dentist (PCD) Last Name

PCD First Name

PCD Number

Current Patient of PCD?

 Y N

Spouse

Social Security Number

Birth Date (MMDDYY)

Gender

 M F

Primary Language (if different)

Last Name (if different)

First Name

MI

PCP Last Name

PCP First Name

PCP No.

Current Patient of PCP?

 Y N

Dependent 1

Social Security Number

Birth Date (MMDDYY)

Gender

 M F

Primary Language (if different)

Last Name (if different)

First Name

MI

PCP Last Name

PCP First Name

PCP No.

Current Patient of PCP?

 Y N

Relationship: Child FT Student[¥] Disabled Child[§]

Dependent 2

Social Security Number

Birth Date (MMDDYY)

Gender

 M F

Primary Language (if different)

Last Name (if different)

First Name

MI

PCP Last Name

PCP First Name

PCP No.

Current Patient of PCP?

 Y N

Relationship: Child FT Student[¥] Disabled Child[§]

Dependent 3

Social Security Number

Birth Date (MMDDYY)

Gender

 M F

Primary Language (if different)

Last Name (if different)

First Name

MI

PCP Last Name

PCP First Name

PCP No.

Current Patient of PCP?

 Y N

Relationship: Child FT Student[¥] Disabled Child[§]

[¥] Must be age 19+ and attend accredited college or university. Submit proof with this form. Proof is required annually.

[§] Please submit Request for Disabled Child form (HAC506) with this form; child must be age 19+.

5. MEDICARE INFORMATION For Medicare eligible only.

Please provide a copy of your Medicare (HIB) card. If a copy is not attached, we cannot process your Medicare benefits request.

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.

Applicant Last Name

First Name

MI

Medicare ID Number

HIB Suffix

Part A Hospital Coverage Start Date (MMDDYY)

Part B Medical Coverage End Date (MMDDYY)

Spouse/Dependent's Last Name (if different)

First Name

MI

Medicare ID Number

HIB Suffix

Part A Hospital Coverage Start Date (MMDDYY)

Part B Medical Coverage End Date (MMDDYY)

6. EMPLOYER INFORMATION This section must be filled in by your group benefits administrator.

Group Name

Address

City

State

Zip

Applicant's Start Date of Full Time Employment (MMDDYY)

Payroll/Department Location

Employee Number

Group Number

Group Sub Number

7. SIGNATURES I have read the certification and fraud statement below.

Applicant Signature

Date (MMDDYY)

Printed Name and Signature of Authorized Group Benefits Administrator

Print

Signature

Date (MMDDYY)

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.

Any other Empire coverage will end upon issuance of this coverage. If I do not agree to transfer my other coverage with Empire to this coverage, I understand that this application will not be accepted by Empire.

I authorize any healthcare provider, healthcare 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 payors, 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.

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.

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 thereto, 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 for each such violation.