

HIP Subscriber/Member Enrollment Form

Last Name	First Name	M.I.	Sex	Social Security Number
Street Address	Apt.	City	State	Zip Code

Were you ever a member of HIP? NO YES
 If yes, indicate policy number(s): _____

Marital Status: Single Married Divorced

Birth Date: Mo. ___ Day ___ Yr. ___

Telephone #: Home: (___) _____ Work: (___) _____
 E-Mail Address: _____

Primary Care Physician: <small>(not required for EPO/PPO members)</small> Physician Name _____ Physician ID Number _____	OB/GYN Selection: <small>(Optional)</small> Physician Name _____ Physician ID Number _____	Qualifying Event: <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Marriage <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> New Hire <input type="checkbox"/> _____ Qualifying Event Date: Mo. ___ Day ___ Yr. ___	Are you covered by any other Health Insurance or Medicare? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, indicate: Insurance Co. Name: _____ Insurance Co. Telephone #: _____ Type of Coverage: _____ Policy #: _____ Effective Date: ___ / ___ / ___
		Is your spouse covered by any other Health Insurance or Medicare? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, indicate: Insurance Co. Name: _____ Insurance Co. Telephone #: _____ Type of Coverage: _____ Policy #: _____ Effective Date: ___ / ___ / ___	

Prior Health Insurance Information

Carrier Name _____ Coverage Begin Date ___/___/___ Coverage End Date ___/___/___

*** If you are enrolling for your spouse and/or children, please list each one below - see Election of Coverage for eligibility**

Last Name (if different)	First Name	Soc. Sec. No.	Sex	Relationship	Birth Date	Check if disabled	Primary Care Physician Name/Number <small>(not required for EPO/PPO members)</small>	OB/GYN Selection Name/Number <small>(Optional)</small>
SPOUSE				<input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Other	Mo. ___ Day ___ Yr. ___			
Prior Health Insurance Information		Carrier Name _____		Coverage Begin Date ___/___/___		Coverage End Date ___/___/___		
ADDITIONAL DEPENDENTS (List oldest first)				<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Mo. ___ Day ___ Yr. ___			
Prior Health Insurance Information		Carrier Name _____		Coverage Begin Date ___/___/___		Coverage End Date ___/___/___		
				<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Mo. ___ Day ___ Yr. ___			
Prior Health Insurance Information		Carrier Name _____		Coverage Begin Date ___/___/___		Coverage End Date ___/___/___		
				<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Mo. ___ Day ___ Yr. ___			
Prior Health Insurance Information		Carrier Name _____		Coverage Begin Date ___/___/___		Coverage End Date ___/___/___		
				<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Mo. ___ Day ___ Yr. ___			
Prior Health Insurance Information		Carrier Name _____		Coverage Begin Date ___/___/___		Coverage End Date ___/___/___		

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 _____

THIS SECTION TO BE COMPLETED BY EMPLOYER/CONTRACTOR GROUP

Name of Group	Group Number	Select One: <input type="checkbox"/> HIP PRIME HMO <input type="checkbox"/> HIPaccess I <input type="checkbox"/> HIP PRIME EPO <input type="checkbox"/> HIP PRIME POS <input type="checkbox"/> HIPaccess II <input type="checkbox"/> HIP PRIME PPO <input type="checkbox"/> HIP SELECT EPO <input type="checkbox"/> HIP SELECT PPO <input type="checkbox"/> HIP CLASSIC HMO		
Requested Effective Date	Hire Date	Employee Title	Date Submitted to HIP	Approved by <i>(Representative of Benefits Administrator)</i>
				Type of Coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Child

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

PROCESSED BY	RECEIVED DATE	PROCESSED DATE
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ELECTION OF COVERAGE

I am enrolling for coverage for myself, my spouse and unmarried children under the age limit shown on the group schedule of benefits who are full time students at an accredited educational institution and who are dependent on me and/or my spouse for support.

If I am required to contribute to the premium for my coverage, I hereby authorize my employer to deduct such contributions in advance from wages due me and to remit same to HIP.

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 be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

HIP PRIME POS and HIP^{access} II applicants please note that your benefits are provided under two separate contracts: a HIP, HMO contract issued by the Health Insurance Plan of Greater New York and HIP PRIME POS and HIP^{access} II contract issued by the HIP Insurance Company of New York. Both contracts will end simultaneously if your HIP PRIME POS or HIP^{access} II coverage ends.

The following paragraph pertains to small business groups only.

I understand that pre-existing conditions will not be covered during the first 12 months of my enrollment under my group's contract. A pre-existing condition is a condition (whether physical or mental) regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended by a duly licensed medical professional or received within the six (6) month period ending on the enrollment date. Except that, pregnancy is not considered a pre-existing condition and genetic information may not be treated as a pre-existing condition in the absence of a diagnosis of the condition related to such genetic information. HIP will credit the time I/we were covered by the previous policy, provided that the break in coverage under this plan does not exceed sixty-three (63) days, exclusive of any waiting periods. I agree that after enrolled, I will upon request provide HIP and/or my medical group with information on pre-existing conditions and any previous coverage I had. Subject to the applicable State and Federal laws pertaining to pre-existing conditions and creditable coverage, benefits for pre-existing conditions may not be payable for up to twelve months from my effective date under my group's contract.

SECTION A

DOCUMENTATION BASED ON GROUP SIZE

(To be completed by Benefits Administrator)

Group Type (Check One)

**Sole Proprietorship
or One Subscriber
Group**

**Association of
Two or More
Employees**

**Small Group -
Less Than 50
Employees**

ACTION Check (✓)One	Qualifying Event	Documentation Required			
<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 copy of Payroll documentation reflecting the date, employee's name and Social Security # and the employee's current year W4 form.	Not Eligible		
<input type="checkbox"/> Add Spouse	Marriage	Marriage Certificate			
<input type="checkbox"/> Add Dependent	Birth	<input type="checkbox"/> Birth Certificate or			
	Adoption	<input type="checkbox"/> Formal Adoption Papers or <input type="checkbox"/> Court Approved Guardianship Papers			
<input type="checkbox"/> Add Spouse	Loss of Coverage	Certificate of Creditable Coverage			
<input type="checkbox"/> Add Dependent					

Note: No Retroactive Enrollments will be allowed. Members must be enrolled within 30 days from the Qualifying Event.