Employee Enrollment Application (Medical, Dental and/or Vision) For 1-100 Employee Small Groups

Empire BlueCross BlueShield
An Anthem Company

The employee who completes this application is solely responsible for its accuracy and completeness.
Be sure to answer all questions and to sign and date your application. Please complete in black ink only.

Section A: Application Type

Select one: ☐ New enrollment ☐ Open enrollment ☐ COBRA ☐ Rehire date: (MM/DD/YYYY) _____/_____/_____

Select qualifying event for special enrollment or COBRA

☐ Loss of dependent child status
☐ Death of subscriber for covered spouse COBRA election
☐ Death of spouse for special enrollment
☐ Employer ends plan contributions
☐ Other group plan ends
☐ Divorce or legal separation from subscriber for covered spouse COBRA election
☐ Legal separation, divorce or annulment for special enrollment
☐ Reduction in hours
☐ COBRA is exhausted
☐ Employment termination
☐ Mandatory Right of Election to continue Dependent coverage through age 29 (qualified dependents only)
☐ Gain or become a dependent via marriage, birth or adoption
☐ Loss of or become eligible for Medicaid or Child Health Plus

Qualifying event date: (MM/DD/YYYY) ____/____ /_____

Section B: Employee Information

Last name	First name	M.I.	Social Security no.[1] (required) / /
Home address - Street and PO Box if applicable	City	State	ZIP code
Primary phone no.	Marital status ☐ Single ☐ Married ☐ Domestic Partner	Marriage date (MM/DD/YYYY) / /	

Email address _____

I'm adding my email address above because I agree 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 benefits, 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 and request a free copy of specific materials by mail. To do either, I will update my communication preferences by going to www.empireblue.com or calling Member Services.

Employer name	Group no. (if known)
Employer street address	City / State / ZIP code

Employment status ☐ Full-time ☐ Part-time ☐ Retired	Date of hire (MM/DD/YYYY) / /	Date of full-time employment (MM/DD/YYYY) / /	Date waiting period begins (MM/DD/YYYY) / /	No. of hours worked per week

Language choice (optional): ☐ English ☐ Spanish ☐ Chinese ☐ Korean ☐ Other — please specify: _____

Section C: Type of Coverage

1. Medical Coverage

Medical product plan name:	Contract code:

Member medical coverage – select one:
☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Family ☐ No coverage

2. Dental Coverage – Indicate the contract code for the dental plan selected. Your employer will advise you of your plan options and contract codes.

Member dental coverage - select one:
☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Family ☐ No coverage

Dental product plan name:	Contract code:

3. Vision Coverage – Indicate the contract code for the vision plan selected. Your employer will advise you of your plan options and contract codes.

Member vision coverage - select one:
☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Family ☐ No coverage

Vision product plan name:	Contract code:

1 Empire BlueCross BlueShield (Empire) is required by the Internal Revenue Service to collect this information.

Section D: Coverage Information – All fields required. Attach a separate sheet if necessary. Complete this section for you and dependents to be covered.

Provide information for any dependents to be covered. An eligible dependent may be your Spouse/Domestic Partner (if this option is selected by your employer), your children, or your Spouse's/Domestic Partner's children, if applicable. If your overage adult dependent qualifies as a disabled person, please complete the Handicap/Dependent Form (HAC 506), which can be found at http://www.empireblue.com/wps/portal/ehpemployer?content_path=employer/noapplication/f4/s3/t0/pw_ad067515.htm&rootLevel=3&label=Forms,

- Your dependent between ages 26-30 may be covered if your employer has selected to extend dependent coverage for adult dependents through age 29 and your dependent qualifies, or you or your dependent have purchased coverage to extend coverage for young adults through age 29 and your dependent is eligible.

List all dependents below beginning with the oldest.

Employee Last name	First name	M.I.
Sex: ☐ Male ☐ Female	Birthdate (MM/DD/YYYY): / /	
PCP name[2]	PCP ID no.	Existing patient ☐ Yes ☐ No
Primary Care Dentist (PCD) name[2]	PCD ID no.	Existing patient ☐ Yes ☐ No

Spouse/Domestic Partner Last name	First name	M.I.	Social Security no.[1] (required) / /
Sex: ☐ Male ☐ Female Birthdate (MM/DD/YYYY) / /	Relationship to applicant: ☐ Spouse ☐ Domestic Partner		
PCP name[2]	PCP ID no.		Existing patient ☐ Yes ☐ No
PCD name[2]	PCD ID no.		Existing patient ☐ Yes ☐ No

Dependent Last name	First name	M.I.	Social Security no.[1] (required) / /
Sex ☐ Male ☐ Female	Birthdate (MM/DD/YYYY) / /	Relationship to applicant ☐ Child ☐ Other If other, what is relationship?_____ ☐ Make available age 29 adult dependent child (rider provided by your employer ☐ Age 29 adult dependent child (rider purchased separately by you or the dependent)	
PCP name[2]	PCP ID no.		Existing patient ☐ Yes ☐ No
PCD name[2]	PCD ID no.		Existing patient ☐ Yes ☐ No
Does this dependent have a different address? ☐ Yes ☐ No If yes, please enter: _____			

Dependent Last name	First name	M.I.	Social Security no.[1] (required) / /
Sex ☐ Male ☐ Female	Birthdate (MM/DD/YYYY) / /	Relationship to applicant ☐ Child ☐ Other If other, what is relationship?_____ ☐ Make available age 29 adult dependent child (rider provided by your employer ☐ Age 29 adult dependent child (rider purchased separately by you or the dependent)	
PCP name[2]	PCP ID no.		Existing patient ☐ Yes ☐ No
PCD name[2]	PCD ID no.		Existing patient ☐ Yes ☐ No
Does this dependent have a different address? ☐ Yes ☐ No If yes, please enter: _____			

1 Empire is required by the Internal Revenue Service to collect this information.

2 To select a PCP and/or PCD, visit our website at www.empireblue.com/find-doctor. If your Empire benefit plan requires you to pick a PCP and/or PCD and you do not select one, we will assign one to you. You will be able to change to another PCP and/or PCD by contacting us.

Employee name: ______________________________ Social Security no.: _____/_____/_____

Section E: Prior and Other Group Coverage

Is anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ No If yes, give name: ____

Medicare ID no.	Part A effective date (MM/DD/YYYY) / /	Part B effective date (MM/DD/YYYY) / /	Medicare eligibility reason(select all that apply) ☐ Age ☐ Disability ☐ ESRD: Onset date (MM/DD/YYYY) _____/_____/_____

Medicare Part D ID no.	Medicare Part D Carrier	Part D effective date (MM/DD/YYYY) / /

Is anyone applying for coverage covered by other health insurance? ☐ Yes ☐ No If yes, please provide the following:

Name of person covered (Last, First, M.I.)	Type (select one)	Coverage (select all that apply)	Insurer name	Insurer phone no.	Policy ID no.	Dates (if applicable) (MM/DD/YYYY)
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				Start: ____/_____/______ End: ____/_____/______
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				Start: ____/_____/______ End: ____/_____/______
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				Start: ____/_____/______ End: ____/_____/______
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				Start: ____/_____/______ End: ____/_____/______
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				Start: ____/_____/______ End: ____/_____/______

Section F: Waiver/Declining Coverage – Proof of coverage will be required.

Medical coverage declined for - select all that apply: ☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)
Dental coverage declined for - select all that apply: ☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)
Vision coverage declined for - select all that apply: ☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)

By signing below, I hereby certify that I have been given the opportunity to apply for the available benefits offered by my employer, the benefits have been explained to me, and I and/or my dependent(s) decline to participate. Neither I nor my dependent(s) were induced or pressured by my employer, agent, or life carrier, into declining this coverage, but elected of my (our) own accord to decline coverage. I understand that if I wish to apply for such coverage in the future, I may be required to provide evidence of insurability at my own expense.

Sign here only if you are declining coverage.

Signature of applicant X	Printed name	Today's date (MM/DD/YYYY) / /

Section G: Terms, Conditions and Authorizations – Please read this section carefully before signing the application.

Eligible dependent:

- Employee's Spouse, or children age 26 or younger, which includes a newborn, natural child, or a child placed with the employee for adoption, a stepchild or any other child for whom the employee is a court-appointed legal guardian if the child is chiefly dependent on you. The age limit for coverage of a child is (1) age 26 unless the employer has selected extended dependent coverage and the dependent qualifies, or, (2) you or the dependent have purchased coverage to extend coverage for young adults through age 29 and your dependent is eligible. In the case of (1) or (2), the dependent age limit for coverage is age 30. Coverage for children will end on the last day of the month in which the children reach age 26, or age 30 if applicable.
- The contract age limit does not apply for an unmarried child who is incapable of self-sustaining employment because of mental illness, developmental disability, or mental retardation (as defined in the NYS mental hygiene law), or physical handicap. The child must have been incapacitated before s/he reached the age at which coverage would otherwise end under the benefit plan. The child must be chiefly dependent on the member for support and maintenance and must remain in the incapacitated condition to remain eligible. The member must submit proof of the child's incapacity within 31 days of reaching the termination age that would otherwise apply.
- Dependents eligible for continued coverage under New York State or federal laws.

Health Savings Account enrollees:
If you want to establish a Health Savings Account (HSA) in conjunction with an HSA-compatible health plan you will need to enter into an agreement with a bank to function as the financial custodian of your HSA. You will need to authorize the financial custodian to provide Empire with information regarding your HSA. By signing below you hereby authorize the financial custodian to provide Empire with information about your HSA, including account number, account balance and information regarding account activity. You also may provide Empire with a written request to revoke this authorization at any time.

Employee name: _____ Social Security no.: _____/_____/_____

In signing this application I represent that:

- I have read or have had read to me the completed application, and I realize any false statement or misrepresentation in the application may result in loss of coverage.
- I certify each Social Security number listed on this application is correct.
- As an eligible employee, I am requesting coverage for myself and all eligible dependents listed and authorize my employer to deduct any required contributions for this insurance from my earnings. I understand all benefits are subject to conditions stated in my employer's Group Contract and my benefit coverage document

INSURANCE FRAUD STATEMENT: 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 a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Sign here	Applicant signature X	Today's date (MM/DD/YYYY) / /

Special Enrollment Rights for Medical Coverage Only

If you declined enrollment for yourself or your dependent(s) (including a Spouse) because of other group health plan coverage, you can enroll yourself and your dependent(s) in this plan if you or your dependent(s) lose eligibility for the other group health plan due to any of the following: termination of employment; termination of the other group health plan; death of your Spouse; legal separation, divorce or annulment; reduction of hours of employment; employer contributions toward the group health plan were terminated; or a child no longer qualifies for coverage as a child under the other group health plan. You must request enrollment within 31 days after coverage ends (or after the employer stops contributing toward the other coverage).

You may also enroll 31 days from the date you exhaust COBRA or state continuation coverage. In addition, if you have a dependent as a result of birth, adoption or placement for adoption, you may enroll yourself and your dependent(s) with newborn coverage starting on the date of birth provided that you request enrollment within 60 days after the birth, adoption or placement for adoption. Otherwise, coverage begins on the date we receive notice of the birth or adoption, provided you pay any additional premium when due. If you get married while covered, you can add your Spouse effective on the date of your marriage if you tell us with 31 days. Otherwise, you must wait until your next open enrollment period. You, your Spouse or child can also enroll within 60 days of the occurrence of the following circumstance: Either you or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility or you, your Spouse or child become eligible for Medicaid or CHIP.

Sign here	Company officer signature X	Printed name	Title
Group no.		Tax ID no.	Today's date (MM/DD/YYYY) / /

Get help in your language

Language Assistance Services

Empire BlueCross BlueShield
An Anthem Company

Curious to know what all this says? We would be too. Here's the English version:
If you need assistance to understand this document in an alternate language, you may request it at no additional cost by calling the Member Services number (855-748-1806). (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the Member Services telephone number on the back of your ID card.

Spanish
Si necesita ayuda para entender este documento en otro idioma, puede solicitarla sin costo adicional llamando al número de Servicios para Miembros (855-748-1806). (TTY/TDD: 711)

Albanian
Nëse ju nevojitet ndihmë për ta kuptuar këtë dokument në një gjuhë tjetër, mund ta kërkoni pa kosto shtesë duke telefonuar në numrin e shërbimeve për anëtarët (855-748-1806). (TTY/TDD: 711)

Arabic
إذا احتجت إلى المساعدة لفهم هذا المستند بلغة أخرى، فيمكنك طلب المساعدة دون تكلفة إضافية من خلال الاتصال برقم خدمات الأعضاء (855-748-1806). (TDD/TTY: 711)

Bengali
একটি বিকল্প ভাষায় এই তথ্য পুস্তিকাটি বোঝার জন্য। যদি আপনার সহায়তার প্রয়োজন হয়, তাহলে কোনো অতিরিক্ত খরচ ছাড়া সদস্য পরিষেবা নম্বর (855-748-1806)-তে কল করে আপনি এটির অনুরোধ করতে পারেন। (TTY/TDD: 711)

Chinese
如果您需要協助以便以另一種語言理解本文件，您可以撥打成員服務號碼(855-748-1806)請求免費協助。(TTY/TDD: 711)

French
Si vous avez besoin d'aide pour comprendre ce document dans une autre langue, vous pouvez en faire la demande gratuitement en appelant les Services destinés aux membres au numéro suivant : 855-748-1806. (TTY/TDD: 711)

Greek
Αν χρειαστείτε βοήθεια για να κατανοήσετε το παρόν έγγραφο σε άλλη γλώσσα, μπορείτε να τη ζητήσετε χωρίς πρόσθετο κόστος καλώντας τον αριθμό του Τμήματος Υπηρεσιών Μέλους (855-748-1806). (TTY/TDD: 711)

Haitian
Si ou bezwen èd pou konprann dokiman sa a nan yon lòt lang, ou kapab rele nimewo Manm Sèvis la pou mande asistans gratis nan nimewo (855-748-1806). (TTY/TDD: 711)

Italian
Se ha bisogno di assistenza per la comprensione del presente documento in un'altra lingua, può richiederla senza alcun costo aggiuntivo chiamando il numero dedicato ai Servizi per i membri (855-748-1806). (TTY/TDD: 711)

Korean
다른 언어로 본 문서를 이해하기 위해 도움이 필요하실 경우, 추가 비용 없이 회원 서비스 번호(855-748-1806)로 전화를 걸어 도움을 요청할 수 있습니다. (TTY/TDD: 711)

Polish
Jeśli potrzebujesz pomocy w zrozumieniu niniejszego dokumentu w innym języku, możesz ją uzyskać bez ponoszenia dodatkowych kosztów, dzwoniąc do Działu Obsługi Klienta pod numer (855-748-1806). (TTY/TDD: 711)

Russian
Если вам нужна помощь, чтобы понять содержание настоящего документа на другом языке, вы можете бесплатно запросить ее, позвонив в отдел обслуживания участников (855-748-1806). (TTY/TDD: 711)

Tagalog
Kung kailangan ninyo ng tulong upang maunawaan ang dokumentong ito sa ibang wika, maaari ninyo itong hilingin nang walang karagdagang bayad sa pamamagitan ng pagtawag sa Member Services sa numerong (855-748-1806). (TTY/TDD: 711)

Urdu
تو آپ ممبر سروس نمبر پر کال اگر آپ کو کسی دوسری زبان میں اس دستاویز کو سمجھنے کے لیے مدد کی ضرورت ہو
جس کے لئے آپ پر کوئی اضافی اخراجات عائد نہیں ہوں گے نمبر کرکے اس کی درخواست کرسکتے ہیں
(711:TDD/TTY) (855-748-1806)

Yiddish
אויב איר דארפט הילף צו פארשטיין דעם דאקומענט אין אן אנדערע שפראך, קענט איר עס בעטן אהן קיין
עקסטערע קאסט דורך רופן די מעמבער באדינונגען נומער
(711:TDD/TTY) (855-748-1806)

It's important we treat you fairly
That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.