healthfirst®
Health Insurance for New Yorkers

Healthfirst Insurance Company, Inc.

Small Group
Add/Change/Delete Application

Mailing Address:
Healthfirst Insurance Company, Inc., Commercial Sales, 100 Church Street, New York, NY 10007
Broker Service: 1-855-456-3668
Employer Services: 1-855-949-3668

A. Employee	Group
Healthfirst Member ID*	Group ID
Employee Name	Group Name
_____ _____/_____/_____ Employee Signature Date _____ Title	_____ _____/_____/_____ Employee Signature Date

B. Transaction	Requested Effective Date**	Required Information
☐ **Addition**	_____/_____/_____	**Whom:** ☐ Spouse ☐ Domestic Partner ☐ Dependent(s) **Reason:** ☐ Open Enrollment ☐ Loss of Coverage ☐ Birth/Adoption ☐ Marriage ☐ Partnership ☐ Other:_____
☐ **Termination**	_____/_____/_____	**Whom:** ☐ Employee ☐ Spouse/Partner ☐ Dependent(s) ☐ NY Young Adult **Reason:** ☐ Left Employer ☐ Discontinuation of COBRA/State Continuation ☐ Switched Plans ☐ Discontinuation of NY Young Adult ☐ Other:_____
☐ **Change**	_____/_____/_____	**Whom:** Last Name:_____First Name:_____ Middle Initial _____ Effective Date _____/_____/_____ SSN _____-_____-_____ Date of Birth _____/_____/_____ Gender ☐ Male ☐ Female **Reason:** _____ _____
COBRA or State Continuation	_____/_____/_____	**Whom:** ☐ Employee ☐ Spouse/Partner ☐ Dependent(s) **Reason:** ☐ Left Employer ☐ Reduction in Hours ☐ Other: _____ Date of termination/Loss of coverage _____/_____/_____
Select a Plan	_____/_____/_____	☐ Healthfirst Pro EPO _____ ☐ Healthfirst Pro Plus EPO _____ ☐ Young Adult Please select from the plan(s) that your employer is offering to you. Check with your employer or plan administrator if there are any questions.

*Required if you are requesting a termination or change to your coverage.
**Healthfirst Insurance Company, Inc. will assign actual effective date if application is approved. Healthfirst reserves the right to request additional documentation as part of our review process.

Employee/Dependent(s) Information

Please complete the form below for the individual(s) you would like to include in the plan.

	Employee/Subscriber	Spouse/Domestic Partner	Dependent 1	Dependent 2
Social Security Number (or Tax Identification Number, if applicable)	_____-_____-_____	_____-_____-_____	_____-_____-_____	_____-_____-_____
Last Name				
First Name, Middle Initial				
Phone Number				
Email Address				
Date of Birth (MM/DD/YYYY)	/ /	/ /	/ /	/ /
Gender	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Primary Care Physician (PCP) Name				
PCP ID Number (if available)*				
Currently covered under another insurance?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If Yes, select type:	☐ Medical ☐ Dental	☐ Medical ☐ Dental	☐ Medical ☐ Dental	☐ Medical ☐ Dental
Company Name				
Coverage Beginning/End Dates	___/___/___ – ___/___/___	___/___/___ – ___/___/___	___/___/___ – ___/___/___	___/___/___ – ___/___/___
Policy Number				

*If you do not select a PCP, one will be auto-assigned to you.

Employee/Dependent(s) Information (continued)

	Dependent 3	Dependent 4	Dependent 5	Dependent 6
Social Security Number (or Tax Identification Number, if applicable)	_____-_____-_____	_____-_____-_____	_____-_____-_____	_____-_____-_____
Last Name				
First Name, Middle Initial				
Phone Number				
Email Address				
Date of Birth (MM/DD/YYYY)	/ /	/ /	/ /	/ /
Gender	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Primary Care Physician (PCP) Name				
PCP ID Number (if available)*				
Currently covered under another insurance?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If Yes, select type:	☐ Medical ☐ Dental	☐ Medical ☐ Dental	☐ Medical ☐ Dental	☐ Medical ☐ Dental
Company Name				
Coverage Beginning/End Dates	___/___/___ – ___/___/___	___/___/___ – ___/___/___	___/___/___ – ___/___/___	___/___/___ – ___/___/___
Policy Number				

*If you do not select a PCP, one will be auto-assigned to you.

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Notice of Non-Discrimination

Healthfirst complies with Federal civil rights laws. **Healthfirst** does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Healthfirst provides the following:

- Free aids and services to people with disabilities to help you communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose first language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call **Healthfirst** at **1-866-305-0408**. For TTY/TDD services, call 1-888-542-3821.

If you believe that **Healthfirst** has not given you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with Healthfirst by:

- **Mail:** Healthfirst Member Services, P.O. Box 5165, New York, NY, 10274-5165
- **Phone: 1-866-305-0408** (for TTY/TDD services, call 1-888-542-3821)
- **Fax:** 1-212-801-3250
- **In person:** 100 Church Street, New York, NY 10007
- **Email: http://healthfirst.org/members/contact/**.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by:

- **Web:** Office for Civil Rights Complaint Portal at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**
- **Mail:** U.S. Department of Health and Human Services
  200 Independence Avenue SW., Room 509F, HHH Building
  Washington, DC 20201
  Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**
- **Phone: 1-800-368-1019** (TTY/TDD 800-537-7697)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-305-0408, TTY/TDD: 1-888-867-4132.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-866-305-0408, TTY/TDD: 1-888-542-3821。

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم العناية بالعملاء 1-866-305-0408 (لخدمات الهاتف النصي/جهاز التواصل عن بعد للصم، اتصل برقم 1-888-542-3821).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-305-0408, TTY/TDD: 1-888-542-3821 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-305-0408, телетайп: 1-888-542-3821.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-305-0408, TTY/TDD: 1-888-542-3821.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-305-0408, TTY/TDD: 1-888-542-3821.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-305-0408, TTY/TDD: 1-888-542-3821.

אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-866-305-0408 TTY/TDD: 1-888-542-3821.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-305-0408, TTY/TDD: 1-888-542-3821.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-305-0408, TTY/TDD: 1-888-542-3821.

দৃষ্টি আকর্ষণ: যদি আপনি বাংলায় কথা বলেন তাহলে বিনামূল্যে ভাষা বিষয়ক সহায়তা আপনার জন্য উপলব্ধ রয়েছে। গ্রাহক সেবায় 1-866-305-0408 (TTY/TDD পরিষেবার জন্য, 1-888-542-3821 নম্বরে ফোন করুন) নম্বরে ফোন করুন।

KUJDES: Nëse flisni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-866-305-0408, TTY/TDD: 1-888-542-3821.

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-866-305-0408, Γραφομηχανή τηλεφώνου (TTY) / Συσκευή τηλεπικοινωνιών για κωφούς (TDD): 1-888-542-3821.

توجہ: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کسٹمر کیر سے گفتگو کرنے کے لئے اس نمبر (1-866-305-0408) پر اور TTY/TDD کے لئے (1-888-542-3821) پر رابطہ کریں۔