

## **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 8.

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)	<b>B. Change</b> (fill in all circles that apply)												
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.	For all circles filled in below, please supply new information in Section 4.												
Open Enrollment Date of Change (MMDDYY)	O Name O Address												
Status Change (fill in one circle below)	HMO/Direct HMO Primary Care Physician (PCP)												
🔿 Marriage 🔵 Newborn 🔵 Adoption 🔵 Retirement	Managed Dental Primary Care Dentist (PCD)												
Medicare Eligible (answer questions below)	If your company offers an Empire Dental plan												
Eligibility criteria (fill in one circle only) 🔿 Age 65+ 🔿 Disability 🔿 End Stage Renal Disease	C. Cancel Coverage (fill in one circle only)												
Active employee? O Yes O No	Note: If you are canceling your own coverage, please have your employer fill out an Employee Termination Form. For other												
Electing company coverage as primary coverage? O Yes O No	cancellations, please fill in the appropriate circle below and enter the name in the Spouse/Dependent portion in Section 4.												
Electing Medicare-related coverage as primary coverage? O Yes O No	Spouse/Dependent												
(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	O Death O Divorce												
	O Dependent no longer eligible												
COBRA/NYS Continuation of Coverage     Nature of COBRA/	O Other:												
NYS Event:	Date of Event (MMDDYY)												
O Other:													
2. BENEFITS SELECTION													
	ty: O Hospital/Medical <b>or</b> O Hospital Only O Other												
O DPOS O DSPOS O Empire Total Blue <sup>ss</sup> Choice (HSA) <sup>†</sup> O Empire Total Blue <sup>s</sup>	of a Health Savings Account in your name, as directed by your												
Coverage Type (fill in one circle only) O Individual O Husband/Wife O Parent/Child(r	en) O Family Employer.												
Dental Insurance <sup>‡</sup> (fill in one circle only) O PPO Dental O Managed Dental O Voluntary Den	tal O Other Dental tal O Other Dental Empire Dental plan												
Coverage Type (fill in one circle only) O Individual O Husband/Wife O Parent/Child(red)													
3. CUSTOMER SERVICE SELECTION activate at www.empireblue.com													
Fill in <b>all</b> the circles of the following telephone and Internet services you wish to use:	n information to much mail address in Costion 4												
I want a secure, personalized website at www.empireblue.com. Send my activatio	n information to my e-mail address in Section 4.												
O Whenever possible, send my plan information to me through <i>www.empireblue.com</i> in	stead of the mail.												
I plan to continue using 1-800 numbers to call customer service.	I												
4. APPLICANT AND SPOUSE/DEPENDENT INFORMATION													
Note: If you've chosen HMO/Direct HMO, please provide a primary care physician (PCP) for yourself and for each depert to HMO/Direct HMO members except for emergency care. If you've chosen Managed Dental, please provide one Prime													
Last Name First Name	MI												
Social Security Number Gender Birth Date (MMDDYY)													
	Marital Status Date of Marriage (MMDDYY)												
	Marital Status Date of Marriage (MMDDYY)												
	Marital Status Date of Marriage (MMDDYY)												

Services provided by Empire HealthChoice HMO, Inc. and/or Empire HealthChoice Assurance, Inc., licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

Home Address       -         Home Address       -         Apt. No.       City         Status       City         PCP Last Name       PCP First Name         PCP Last Name       PCP Number         Social Security Number       Birth Date (MMDDYY)         Gender       Primary Language (f different)         PCP Last Name       NI         PCP Last Name       PCP No.         Camera Patient of PCP         Social Security Number       Birth Date (MMDYY)         Gender       Primary Language (f different)         PCP Last Name       PCP No.         Camera Patient of PCP         Social Security Number       Birth Date (MMDYY)         Gender       PCP Pirst Name         PCP Last Name       PCP Pirst Name	4	. AP Home	PLIC e Pho			ND S	SPO	USI	E/DE	PE	NDE	NT	INF	ORN Dayti	<b>IATI</b> ime P	ON Phone	(con	ntinue	ed)															
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Current Patient of PCP         Relationship:       Child         FT Student*       Disabled Child         Social Security Number       Birth Date (MMDDYY)         Gender       Primary Language (if different)         Last Name (if different)       First Name         PCP Last Name       PCP First Name         PCP Last Name       PCP No.         Current Patient of PCP?         Social Security Number       Birth Date (MMDDYY)         Gender       Primary Language (if different)         PCP Last Name       PCP No.         Current Patient of PCP?         Social Security Number       Birth Date (MMDDYY)         Gender       Primary Language (if different)         PCP Last Name       PCP No.         Current Patient of PCP?         Social Security Number       Birth Date (MMDDYY)         Gender       Primary Language (if different)         Last Name (if different)       First Name         PCP Last Name       PCP No.         Current Patient of PCP?       Y         N       First Name         PCP Last Name       PCP No.         Current Patient of PCP?         Y       N         PCP Last Name       PCP No.         <	epen			lom												First	Nom							No										
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Known and attend accredited college or university. Submit proof with this form. Proof is required annually.     ENR0296BP2		Relat	ionsh	ip: (	Cr	nild	O F	T St	udent	¥ C	Dis	sabled	d Chi	d§																	ı			
§ Please submit Request for Disabled Child form (HAC506) with this form; child must be age 19+.	_		-		¥ ه	lust b	e age	19+ a	and at	tend a	ccred	ited co	ollege	or un	iversit	y. Su	bmit p	proof w	ith thi	s form	n. Pro	oof is r	equire	ed ann	ually.	ΕN	IR0	296	BP	2 -		_		

5. OTHER COVERAGE INFORMATION														
Do you currently have or have you had health insurance in the past 11 months?														
O     YES     Coverage Start Date (MMDDYY):     Coverage End Date (MMDDYY):														
Has the coverage been continuous during the past 11 months?														
Will your current group insurance remain in effect after you enroll in this Empire plan? O Yes O No														
Name of Other Insurance Carrier     Your ID Number from Other Carrier														
Name of Other Insurance Carrier       Your ID Number from Other Carrier         So       So														
Coverage Provided by Employer? Yes No Employment Status: Active Retired														
Contract Type: Husband/Wife Individual Parent/Child(ren) Family														
Coverage Type: O Hospital/Medical O Hospital Only O Medical Only O Other:														
O NO														
Does your spouse / dependent(s) currently have or have they had health insurance in the past 11 months?														
O YES Coverage Start Coverage End Date (MMDDYY):														
Has the coverage been continuous during the past 11 months?														
Will their current group insurance remain in effect after you enroll in this Empire plan? O Yes O No														
O My spouse has or has had the same coverage as I. Note: You do not need to fill out the rest of the spousal other coverage questions.														
<ul> <li>My spouse has of has had the same coverage as I. Note: You do not need to fill out the rest of the dependent other coverage questions.</li> <li>My dependents have or have had the same coverage as I. Note: You do not need to fill out the rest of the dependent other coverage questions.</li> </ul>														
Name of Spouse's Other Carrier ID Number														
Coverage Start Date (MMDDYY) Coverage End Date (MMDDYY) Coverage Provided O Yes O No Employment Status: O Active	Retired													
by Employer?														
Contract Type: Husband/Wife Individual Parent/Child(ren)														
Coverage Type: O Hospital/Medical O Hospital Only O Medical Only O Other:														
Name of Dependent's Other Insurance Carrier ID Number														
Coverage Start Date (MMDDYY) Coverage End Date (MMDDYY) Coverage Provided O Yes O No Employment Status: O Active O	Retired													
Coverage Start Date (MMDDYY) Coverage End Date (MMDDYY) Coverage Provided by Employer? Ves O No Employment Status: O Active O by Employer? Contract Type: O Husband/Wife O Individual O Parent/Child(ren) Coverage Type: O Hospital/Medical O Hospital Only O Medical Only O Other:	) Family													
Coverage Type: O Hospital/Medical O Hospital Only O Medical Only O Other:														
Name of Dependent's Other Insurance Carrier ID Number														
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Contract Type: O Husband/Wife O Individual O Parent/Child(ren)	Family													
Coverage Type: O Hospital/Medical O Hospital Only O Medical Only O Other:														
Name of Dependent's Other Insurance Carrier     ID Number														
Coverage Start Date (MMDDYY) Coverage End Date (MMDDYY) Coverage Provided Ores No Employment Status: O Active O O	Retired													
Contract Type: O Husband/Wife O Individual O Parent/Child(ren)	) Family													
Coverage Type: O Hospital/Medical O Hospital Only O Medical Only O Other:														
O NO ENR0296BP3														

Please provide a c							-													_								
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	Applicant Last Name First Name																		_	MI	_							
																										•	)	
Medicare ID Nu	ımber					_	HIBS	Suffix		Pa	art A H	ospital	Cover	age St	tart Da	te (MN	NDDY	Y)	Part	B Med	lical Co	overag	ge End	1 Date	(MM	IDDY	r)	
Spouse/Depen	dent's Las	st Nam	ne (if	differ	ent)	-				-		_	First I	Name	Э		_	_					_	MI				
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7. EMPLOYER	INFOR	MATI	ON	Th	nis se	ectio	n mu	st be	filleo	d in k	ру уо	ur gr	oup b	enet	fits a	dmin	istra	tor.										
Group Name																											_	
Address																												
City							-						;	State			Zip	-										
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Applicant's Start [	Date of Full	Time	-mplo	vmen	t (MN)	יצחחו	() Pa	vroll/	Dena	Intmo	ntlo	cation					Empl	ovec	Nun	her		J						
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Group Number				Gro	up S	ub Nı	umbei	r																				
8. SIGNATURE	S I hav	e read	d the	certi	ificat	ion a	nd fr	aud s	state	ment	t belo	ow.																
Applicant Signature											_	Dete	/N 4N 4		00													
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Printed Name a	and Signa	ture of	f Auth	orize	ed Gr	oup E	Benef				or										Data	/h /h /		00				
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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.

6. MEDICARE INFORMATION For Medicare eligible only.

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.