GHI

Please Return Enrollment Materials to:
Conference Associates Inc.
180 East Main Street
P.O. Box 969
Patchogue, NY 11772
1-800-99-NYSBG

A. REASON(S) FOR SUBMISSION – Check one or more of the boxes below that apply.

☐ New Enrollment
☐ Reinstatement
☐ Termination
☐ Address Change
☐ Name Change
Former Name _____

☐ **Change Contract To:** ☐ Individual ☐ Husband/Wife ☐ Parent & Child(ren) ☐ Family ☐ Medicare Carve-Out

TRANSFER
☐ To Another Carrier
☐ From GHI Group No. _____
To GHI Group No. _____

CHANGE OF DEPENDENTS
☐ Add Spouse
☐ Delete Spouse
☐ Add Child(ren)
☐ Delete Child(ren)

B. SUBSCRIBER INFORMATION

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NO.	EMPLOYMENT DATE

HOME ADDRESS	APT#	DATE OF BIRTH	SEX
			☐ MALE ☐ FEMALE

CITY	STATE	ZIP CODE	MARITAL STATUS: ☐ SINGLE ☐ MARRIED
			EMPLOYMENT STATUS: ☐ EMPLOYED ☐ NOT EMPLOYED ☐ RETIRED ☐ COBRA

Telephone number where you can be reached between 9:00am and 5:00pm Monday through Friday ( ) _____

C. DO YOU HAVE PRIOR HEALTH COVERAGE Yes ☐ or No ☐ Please provide a 12-month history of all coverages below.

	Name and Address of Insurer	Telephone Number of Insurer	Name of Policyholder	Policy I.D. Number	Effective Date of Current or Prior Policy	Termination Date of Current or Prior Policy
Hospital						
Medical						

D. DEPENDENT INFORMATION – List all dependent family members below (including spouse) to be covered or terminated.

(INDICATE DIFFERENT LAST NAME IF APPLICABLE)			DATE OF BIRTH	RELATIONSHIP	FULL TIME STUDENT YES OR NO	ADD ✓	DELETE ✓
LAST NAME	FIRST NAME	MI			If Yes, see #3 on reverse side		

E. OTHER CARRIER INFORMATION

Do you or any of your dependents have other health care coverage? ☐ Yes ☐ No If "Yes", please complete the following information:

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NO.

OTHER HEALTH INSURANCE CARRIER INFORMATION	POLICY NUMBER	EFFECTIVE DATE	NAME OF CARRIER

CARRIER'S ADDRESS	CITY	STATE	ZIP CODE

F. SUBSCRIBER AUTHORIZATION

Please read statement on the back of this form before signing this document

SUBSCRIBER'S SIGNATURE _____ DATE ___/___/___

GROUP AUTHORIZATION

AUTHORIZED SIGNATURE _____ DATE ___/___/___

G. GROUP'S NAME AND ADDRESS	EFFECTIVE DATE OF TRANSACTION	GHI GROUP NUMBER
	MEDICAL	MEDICAL
	HOSPITAL	HOSPITAL
	DENTAL	DENTAL