EmblemHealth™

TRANSACTION FORM FOR GROUP ACCOUNTS

MEMBERSHIP/P.O. BOX 2820 • NEW YORK, NY 10116-2820

(Please read important information on back before completing this form)

Employers: See back for sections you must complete

PLEASE PRINT CLEARLY

INTERNAL USE ONLY
CONTROL NUMBER

I. SUBSCRIBER INFORMATION

LAST NAME	FIRST NAME	M.I.	TELEPHONE NUMBERS HOME WORK EMAIL ADDRESS
HOME ADDRESS APT. NO.	SOCIAL SECURITY NUMBER (REQUIRED)		GENDER ☐ Male ☐ Female
CITY STATE ZIP CODE			PRIMARY LANGUAGE SPOKEN

MARITAL STATUS ☐ Single ☐ Married ☐ Other _____

II. ENROLLMENT INFORMATION

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH MO/DAY/YR	SOCIAL SECURITY NUMBER (REQUIRED)	GENDER	RELATIONSHIP	MAILING ADDRESS (If different from above)	Required for EH CompreHealth: PRIMARY CARE PHYSICIAN ID Number	Required for EH CompreHealth: OB/GYN SELECTION ID Number	ADD ✓	DELETE ✓
SUBSCRIBER						SELF					
SPOUSE											
DEPENDENT											
DEPENDENT											
DEPENDENT											

III. OTHER CARRIER INFORMATION

Do you or any of your dependents have other health care coverage? ☐ Yes Please complete this section ☐ No GO TO SECTION IV

NAME OF SUBSCRIBER'S OTHER INSURANCE CARRIER	INSURANCE CO. PHONE #	TYPE OF CONTRACT ☐ Group ☐ Individual ☐ Family	NAME OF POLICYHOLDER: LAST NAME FIRST NAME M.I.	POLICY ID. NUMBER	EFFECTIVE DATE
NAME OF SPOUSE'S OTHER INSURANCE CARRIER/MEDICARE	INSURANCE CO. PHONE #	TYPE OF CONTRACT ☐ Group ☐ Individual ☐ Family	NAME OF POLICYHOLDER: LAST NAME FIRST NAME M.I.	POLICY ID. NUMBER	EFFECTIVE DATE

IV. DID YOU HAVE PRIOR HEALTH COVERAGE?

☐ YES Please provide a 12-month history of all coverage in this section (Use additional pages if you need more space) ☐ NO GO TO SECTION V

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

V. PRE-EXISTING CONDITIONS

Pre-existing conditions will not be covered during the first twelve (12) months of enrollment in the EmblemHealth CompreHealth program or during the first eleven (11) months of enrollment in the EmblemHealth EPO, EmblemHealth PPO, EmblemHealth InBalance EPO, EmblemHealth InBalance PPO, EmblemHealth ConsumerDirect PPO or EmblemHealth ConsumerDirect EPO. A pre-existing condition is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice or treatment was recommended or received during the six (6) month period prior to your enrollment date. EmblemHealth will credit the time you were covered by prior creditable health insurance coverage toward the twelve (12) month or eleven (11) month period, as long as the break in coverage between the prior coverage and your EmblemHealth coverage does not exceed sixty-three (63) days, exclusive of any waiting periods. If requested, you or your group must provide EmblemHealth with information about your pre-existing conditions and/or previous coverage. You have the right to request a certificate of creditable coverage from your prior health plan. If needed, EmblemHealth will help you get such a certificate from your prior plan.

A large group (51 or more eligible employees) may elect to cover pre-existing conditions from the start of your EmblemHealth coverage. In such a case, your EmblemHeath policy will not contain a pre-existing condition limitation or it will state that the pre-existing condition limitation does not apply.

Please call EmblemHealth at 1-877-VIA-EMBLEM (1-877-842-3625) for more information about the pre-existing condition limitation.

VI. SUBSCRIBER AUTHORIZATION

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.

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 EmblemHealth.

Your signature is required to process this form. Your signature attests that you have read the above, and the reverse side of this form.

_____ _____

Applicant must sign here Date

EmblemHealth insurance plans are underwritten by Group Health Incorporated (GHI), HIP Health Plan of New York (HIP) and HIP Insurance Company of New York.

SEE REVERSE SIDE FOR SECTIONS TO BE COMPLETED BY EMPLOYER, AND TO READ IMPORTANT INFORMATION BEFORE COMPLETING THIS FORM.

VII. EMPLOYER INFORMATION - TO BE COMPLETED BY EMPLOYER (SMALL GROUP EMPLOYERS MUST READ AND COMPLETE SECTION BELOW)

SUBSCRIBER EMPLOYMENT STATUS

☐ Employed ☐ Not Employed | ☐ Retired | ☐ COBRA: ☐ 18 mo. ☐ 36 mo. | ☐ Retiree/RDS - Effective Date _____

EMPLOYEE WAITING PERIOD

☐ YES NUMBER OF WAITING PERIOD DAYS _____

☐ NOT APPLICABLE

NUMBER OF ACTIVE EMPLOYEES IN YOUR GROUP _____

Check one: ☐ New Enrollment ☐ Reinstatement ☐ Termination ☐ Change to Individual Policy

STATUS CHANGE: ☐ Add Dependent ☐ Remove Dependent ☐ Address Change ☐ Name Change Reason for Change: _____

TRANSFER: ☐ To Another Carrier ☐ EmblemHealth Group # Change: From _____ To _____ Is applicant currently working at least 20 hours per week? ☐ Yes ☐ No

NAME OF GROUP	GROUP NUMBER: MED/HOSPITAL: DENTAL	**SELECT ONE:** ☐ EmblemHealth CompreHealth (small groups only) ☐ EmblemHealth CompreHealth EPO (large groups only) ☐ EmblemHealth EPO ☐ EmblemHealth PPO ☐ EmblemHealth InBalance EPO ☐ EmblemHealth InBalance PPO ☐ EmblemHealth ConsumerDirect PPO ☐ EmblemHealth ConsumerDirect EPO

REQUESTED EFFECTIVE DATE MEDICAL: _____ DENTAL: _____	HIRE DATE	DATE SUBMITTED TO EMBLEMHEALTH	APPROVED BY (Group Plan Administrator)/Title	TYPE OF COVERAGE: ☐ INDIVIDUAL ☐ FAMILY ☐ EMPLOYEE & SPOUSE ☐ EMPLOYEE & CHILD

Instructions to Group Plan Administrator: For Groups with 50 employees or less, you **MUST** complete the following documentation section. Required documentation **MUST** be attached to this Transaction Form to be processed.

DOCUMENTATION BASED ON GROUP SIZE (To be completed by Small Group Plan Administrator)

ACTION **Check (✔) One**	**Qualifying Event**	**Group Type (Check One)** → **Documentation Required**	☐ **Sole Proprietorship or One Subscriber Group**	☐ **Association of Two or More Employees**	☐ **Small Group - Less Than 50 Employees**
☐ 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 # **or** the employee's current year W4 form.	Not Eligible		
☐ Add Spouse	Marriage Court Order	❒ Marriage Certificate ❒ Court Order			
☐ Add Dependent	Birth Adoption Court Order	❒ Birth Certificate or ❒ Formal Adoption Papers or ❒ Court Approved Guardianship Papers or ❒ Court Order			
☐ Add Spouse ☐ Add Dependent	Loss of Coverage	Certificate of Creditable Coverage			

Note: No retroactive enrollments will be allowed. Members must be enrolled within 30 days from the qualifying event.

FOR EMBLEMHEALTH USE ONLY

PROCESSED BY	RECEIVED DATE	PROCESSED DATE

IMPORTANT INFORMATION

1. The subscriber must complete sections I through VI. The group plan administrator must complete section VII, and, if for a small group, the documentation section above.
2. All effective dates of transactions may not exceed thirty (30) days retroactive from the next billing date.
3. For group accounts with student dependent coverage: A full-time dependent student is a person who meets all of these conditions: He/she is at least 19 years of age, unmarried, receives at least half of his/her support from the employee or member, and is enrolled full-time in an accredited educational institution. The institution must grant a degree or diploma.

   To enroll the dependent as a full-time student, attach a completed Student Verification Parent Affidavit Form. See your group plan administrator or go to the EmblemHealth Web site at **www.emblemhealth.com** for a Student Verification Parent Affidavit Form.
4. Failure to complete any part of this form (e.g., group number, reason for submission, certificate number, signature, etc.) will require EmblemHealth to return this transaction form to the employer group plan administrator and may delay the requested effective date of coverage.