

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

www.empressucceom												
1. REASON FOR ENROLLMENT/CHANGE Complete section A, B or C.												
A. New Enrollment/Addition (fill in one circle only) 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.	B. Change (fill in all circles that apply) For all circles filled in below, please supply new information in Section 4.											
Open Enrollment Date of Change (MMDDYY)	Name Address											
Status Change (fill in one circle below)	HMO/Direct HMO Primary Care Physician (PCP)											
O Marriage O Newborn O Adoption O 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?	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?	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?	Spouse/Dependent											
(If company size is under 20 employees and end stage renal disease does not apply, you must choose this option)	Death Divorce											
Part-Time to Full-Time	O Dependent no longer eligible											
○ COBRA/NYS Continuation of Coverage	Dependent no longer engine											
Nature of COBRA/ NYS Event:	Other:											
NTO Event.	Date of Event (MMDDYY)											
Other:												
''												
2. BENEFITS SELECTION												
Medical Insurance (fill in one circle only) ○ PPO ○ EPO ○ HMO ○ Direct HMO Indemnity	y: O Hospital/Medical or O Hospital Only Other											
ODPOS ODSPOS Empire Total Blue sM Choice (HSA) [†] Empire Total Blue sM	Choice (HRA) † Empire will facilitate the opening of a Health Savings Account in											
Coverage Type (fill in one circle only) O Individual Husband/Wife Parent/Child(re	your name, as directed by your											
Dental Insurance [‡] (fill in one circle only)	al Other Dental ‡ _{If your company offers an}											
Coverage Type (fill in one circle only) O Individual Husband/Wife Parent/Child(re	Empire Dental plan											
	. army											
3. CUSTOMER SERVICE SELECTION activate at www.empireblue.com Fill in all the circles of the following telephone and Internet services you wish to use:												
I want a secure, personalized website at www.empireblue.com. Send my activation	information to my e-mail address in Section 4.											
	1											
Whenever possible, send my plan information to me through www.empireblue.com ins	stead of the mail.											
I plan to continue using 1-800 numbers to call customer service.	ı											
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 Prima												
Last Name First Name	MI											
Social Security Number Gender Birth Date (MMDDYY)	Marital Status Date of Marriage (MMDDYY)											
Social Security Number Gender Birth Date (MMDDYY) N												
	Married Single											
E-mail Address												

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		OTHER COVERAGE INFORMATION														
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	O	YES Coverage Start Date (MMDDYY): Date (MMDDYY):														
		Has the coverage been continuous during the past 11 months? O Yes O No														
.		Will your current group insurance remain in effect after you enroll in this Empire plan? O Yes O No														
can	or No	Name of Other Insurance Carrier Your ID Number from Other Carrier	_													
Applicant																
	Fill in Yes	Coverage Provided by Employer?														
		Contract Type: Husband/Wife Individual Parent/Child(ren) Family														
	\downarrow	Coverage Type: O Hospital/Medical Only O Medical Only Other:														
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(S)	Does	es your spouse / dependent(s) currently have or have they had health insurance in the past 11 months?														
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e / L		Will their current group insurance remain in effect after you enroll in this Empire plan? O Yes O No														
snoc		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.														
Ś		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 question	วทร													
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