

4. APPLICANT AND SPOUSE/DEPENDENT INFORMATION (continued)

Applicant (cont.)

Home Phone

Daytime Phone

Home Address

Apt. No.

City

State

Zip

Occupation

Primary Language

PCP Last Name

PCP First Name

PCP Number

Current Patient of PCP?

☐ Y ☐ N

Primary Care Dentist (PCD) Last Name

PCD First Name

PCD Number

Current Patient of PCD?

☐ Y ☐ N

Spouse

Social Security Number

Birth Date (MMDDYY)

Gender

☐ M ☐ F

Primary Language (if different)

Last Name (if different)

First Name

MI

PCP Last Name

PCP First Name

PCP No.

Current Patient of PCP?

☐ Y ☐ N

Dependent 1

Social Security Number

Birth Date (MMDDYY)

Gender

☐ M ☐ F

Primary Language (if different)

Last Name (if different)

First Name

MI

PCP Last Name

PCP First Name

PCP No.

Current Patient of PCP?

☐ Y ☐ N

Relationship: ☐ Child ☐ FT Student[¥] ☐ Disabled Child[§]

Dependent 2

Social Security Number

Birth Date (MMDDYY)

Gender

☐ M ☐ F

Primary Language (if different)

Last Name (if different)

First Name

MI

PCP Last Name

PCP First Name

PCP No.

Current Patient of PCP?

☐ Y ☐ N

Relationship: ☐ Child ☐ FT Student[¥] ☐ Disabled Child[§]

Dependent 3

Social Security Number

Birth Date (MMDDYY)

Gender

☐ M ☐ F

Primary Language (if different)

Last Name (if different)

First Name

MI

PCP Last Name

PCP First Name

PCP No.

Current Patient of PCP?

☐ Y ☐ N

Relationship: ☐ Child ☐ FT Student[¥] ☐ Disabled Child[§]

[¥] Must be age 19+ and attend accredited college or university. Submit proof with this form. Proof is required annually.

[§] Please submit Request for Disabled Child form (HAC506) with this form; child must be age 19+.

ENR0296BP2

5. OTHER COVERAGE INFORMATION

Do you currently have or have you had health insurance in the past 11 months?

☐ YES

Coverage Start Date (MMDDYY):

Coverage End Date (MMDDYY):

Has the coverage been continuous during the past 11 months?

☐ Yes ☐ No

Will your current group insurance remain in effect after you enroll in this Empire plan?

☐ Yes ☐ No

Name of Other Insurance Carrier

Your ID Number from Other Carrier

Coverage Provided by Employer?

☐ Yes ☐ No

Employment Status:

☐ Active ☐ Retired

Contract Type:

☐ Husband/Wife

☐ Individual

☐ Parent/Child(ren)

☐ Family

Coverage Type:

☐ Hospital/Medical

☐ Hospital Only

☐ Medical Only

☐ Other:

☐ NO

Does your spouse / dependent(s) currently have or have they had health insurance in the past 11 months?

☐ YES

Coverage Start Date (MMDDYY):

Coverage End Date (MMDDYY):

Has the coverage been continuous during the past 11 months?

☐ Yes ☐ No

Will their current group insurance remain in effect after you enroll in this Empire plan?

☐ Yes ☐ No

☐ 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.

☐ 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.

Name of Spouse's Other Carrier

ID Number

Coverage Start Date (MMDDYY)

Coverage End Date (MMDDYY)

Coverage Provided by Employer?

☐ Yes ☐ No

Employment Status:

☐ Active ☐ Retired

Contract Type:

☐ Husband/Wife

☐ Individual

☐ Parent/Child(ren)

☐ Family

Coverage Type:

☐ Hospital/Medical

☐ Hospital Only

☐ Medical Only

☐ Other:

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Name of Dependent's Other Insurance Carrier

ID Number

Coverage Start Date (MMDDYY)

Coverage End Date (MMDDYY)

Coverage Provided by Employer?

☐ Yes ☐ No

Employment Status:

☐ Active ☐ Retired

Contract Type:

☐ Husband/Wife

☐ Individual

☐ Parent/Child(ren)

☐ Family

Coverage Type:

☐ Hospital/Medical

☐ Hospital Only

☐ Medical Only

☐ Other:

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Name of Dependent's Other Insurance Carrier

ID Number

Coverage Start Date (MMDDYY)

Coverage End Date (MMDDYY)

Coverage Provided by Employer?

☐ Yes ☐ No

Employment Status:

☐ Active ☐ Retired

Contract Type:

☐ Husband/Wife

☐ Individual

☐ Parent/Child(ren)

☐ Family

Coverage Type:

☐ Hospital/Medical

☐ Hospital Only

☐ Medical Only

☐ Other:

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Name of Dependent's Other Insurance Carrier

ID Number

Coverage Start Date (MMDDYY)

Coverage End Date (MMDDYY)

Coverage Provided by Employer?

☐ Yes ☐ No

Employment Status:

☐ Active ☐ Retired

Contract Type:

☐ Husband/Wife

☐ Individual

☐ Parent/Child(ren)

☐ Family

Coverage Type:

☐ Hospital/Medical

☐ Hospital Only

☐ Medical Only

☐ Other:

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☐ NO

ENR0296BP3

For Medicare eligible only.

Please provide a copy of your Medicare (HIB) card. If a copy is not attached, we cannot process your Medicare benefits request.

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.

MI

[illegible][illegible]

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Part B Medical Coverage End Date (MMDDYY)

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[illegible][illegible]

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Part B Medical Coverage End Date (MMDDYY)

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This section must be filled in by your group benefits administrator.

[illegible][illegible]

Zip

[illegible]

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Employee Number

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[illegible]

Group Sub Number

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8. SIGNATURES I have read the certification and fraud statement below.

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Print	Signature
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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.

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.

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.

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.

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.