

Enrollment/Change Form



Thank you for choosing Empire. Please fill out all items in order for us to quickly and accurately process your enrollment. Once you've completed this form, please sign in the space provided in Section 7.

1. REASON FOR ENROLLMENT/CHANGE (COMPLETE SECTION A, B OR C)

A. NEW ENROLLMENT/ADDITION (FILL IN ONE BOX ONLY)

<input type="checkbox"/> New hire (<i>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.</i>)	Date of change (MMDDYY) 																
<input type="checkbox"/> Open enrollment																	
<input type="checkbox"/> Status change (<i>fill in one box</i>) <table style="width:100%; margin-left: 20px;"> <tr> <td><input type="checkbox"/> Marriage</td> <td><input type="checkbox"/> Newborn</td> <td><input type="checkbox"/> Adoption</td> <td><input type="checkbox"/> Retirement</td> </tr> </table>		<input type="checkbox"/> Marriage	<input type="checkbox"/> Newborn	<input type="checkbox"/> Adoption	<input type="checkbox"/> Retirement												
<input type="checkbox"/> Marriage	<input type="checkbox"/> Newborn	<input type="checkbox"/> Adoption	<input type="checkbox"/> Retirement														
<input type="checkbox"/> Medicare eligible (<i>answer questions below</i>) <table style="width:100%; margin-left: 20px;"> <tr> <td>Eligibility criteria (<i>fill in one box only</i>)</td> <td><input type="checkbox"/> Age 65+</td> <td><input type="checkbox"/> Disability</td> <td><input type="checkbox"/> End stage renal disease</td> </tr> <tr> <td>Active employee</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td></td> </tr> <tr> <td>Electing company coverage as primary coverage?</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td></td> </tr> <tr> <td>Electing Medicare-related coverage as primary coverage?</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td></td> </tr> </table> <p><i>(If company size is under 20 employees and end stage renal disease does not apply, you must choose this option)</i></p>		Eligibility criteria (<i>fill in one box only</i>)	<input type="checkbox"/> Age 65+	<input type="checkbox"/> Disability	<input type="checkbox"/> End stage renal disease	Active employee	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Electing company coverage as primary coverage?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Electing Medicare-related coverage as primary coverage?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Eligibility criteria (<i>fill in one box only</i>)	<input type="checkbox"/> Age 65+	<input type="checkbox"/> Disability	<input type="checkbox"/> End stage renal disease														
Active employee	<input type="checkbox"/> Yes	<input type="checkbox"/> No															
Electing company coverage as primary coverage?	<input type="checkbox"/> Yes	<input type="checkbox"/> No															
Electing Medicare-related coverage as primary coverage?	<input type="checkbox"/> Yes	<input type="checkbox"/> No															
<input type="checkbox"/> Part-time to Full-time																	
<input type="checkbox"/> COBRA/NYS Continuation of coverage	Nature of COBRA/NYS event 																
<input type="checkbox"/> Other 																	

B. CHANGE (FILL IN ALL BOXES THAT APPLY)

For all boxes filled in below, please supply new information in Section 3.

<input type="checkbox"/> Name	<input type="checkbox"/> Address	<input type="checkbox"/> Primary Care Physician (PCP) <small>(HMO/Direct HMO/POS/DSPOS plans only)</small>	<input type="checkbox"/> Managed Dental Primary Care Dentist (PCD) <small>(If your company offers an Empire Dental plan)</small>
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C. CANCEL COVERAGE (FILL IN ONE BOX ONLY)

Note: If you are canceling your own coverage, please have your employer fill out an Employee Termination Form. For other cancellations, please fill in the appropriate box below and enter the name in the Spouse/Dependent portion in Section 3.

Spouse/Dependent	<input type="checkbox"/> Death	<input type="checkbox"/> Divorce	<input type="checkbox"/> Dependent no longer eligible	Date of event (MMDDYY)
	<input type="checkbox"/> Other			

2. BENEFITS SELECTION

Medical Insurance¹ (<i>fill in one box only</i>)	<input type="checkbox"/> Direct HMO <input type="checkbox"/> EPO (<i>large group only</i>) <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> DPOS <input type="checkbox"/> DSPOS <input type="checkbox"/> Value EPO (<i>small group only</i>) <input type="checkbox"/> Empire Total Blue SM Choice (HSA) <input type="checkbox"/> Empire Total Blue SM Choice (HRA) <input type="checkbox"/> Empire Prism SM PPO (<i>large group only</i>) <input type="checkbox"/> Empire Prism SM EPO
Indemnity: Coverage type (<i>fill in one box only</i>)	<input type="checkbox"/> Hospital/Medical or <input type="checkbox"/> Hospital Only <input type="checkbox"/> Other <input type="checkbox"/> Individual <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Parent/Child(ren) <input type="checkbox"/> Family
Dental Insurance² (<i>fill in one box only</i>) Coverage type (<i>fill in one box only</i>)	<input type="checkbox"/> PPO Dental <input type="checkbox"/> Managed Dental <input type="checkbox"/> Voluntary Dental <input type="checkbox"/> Other Dental <input type="checkbox"/> Individual <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Parent/Child(ren) <input type="checkbox"/> Family
Vision Insurance³ Blue View VisionSM Coverage type (<i>fill in one box only</i>)	<input type="checkbox"/> Individual <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Parent/Child(ren) <input type="checkbox"/> Family

1 Empire will facilitate the opening of a Health Savings Account in your name, as directed by your Employer.
 2 If your company offers an Empire Dental Plan.
 3 If your company offers a Blue View Vision plan.

3. APPLICANT AND SPOUSE/DOMESTIC PARTNER/DEPENDENT INFORMATION

APPLICANT

Note: If you've chosen HMO/Direct HMO/POS/DSPOS, please provide a primary care physician (PCP) for yourself and for each dependent. Please note that no out-of-network benefits are available to HMO/Direct HMO members except for emergency care. If you've chosen Managed Dental, please provide one Primary Care Dentist (PCD) for you and your dependents.

Last name		First name		M.I.	Social Security no.	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Birthdate (MMDDYY)		Marital status <input type="checkbox"/> Married <input type="checkbox"/> Single		Date of marriage (MMDDYY)
Place of marriage*		State	Country			
Home address					Apt no.	
City					State	ZIP code
Home phone		Daytime phone		Primary language		
Occupation						
PCP Last name		PCP First name		PCP no.	Current patient of PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Primary Care Dentist (PCD) Last name		PCD First name		PCD no.	Current patient of PCD? <input type="checkbox"/> Yes <input type="checkbox"/> No	

SPOUSE/DOMESTIC PARTNER

Last name (if different)		First name		M.I.	Social Security no.	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Birthdate (MMDDYY)	Primary language (if different)			
PCP Last name		PCP First name		PCP no.	Current patient of PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No	

DEPENDENT 1

Last name (if different)		First name		M.I.	Social Security no.	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Birthdate (MMDDYY)	Primary language (if different)			
PCP Last name		PCP First name		PCP no.	Current patient of PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Relationship: <input type="checkbox"/> Child <input type="checkbox"/> FT student** <input type="checkbox"/> Disabled child***						

DEPENDENT 2

Last name (if different)		First name		M.I.	Social Security no.	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Birthdate (MMDDYY)	Primary language (if different)			
PCP Last name		PCP First name		PCP no.	Current patient of PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Relationship: <input type="checkbox"/> Child <input type="checkbox"/> FT student** <input type="checkbox"/> Disabled child***						

DEPENDENT 3

Last name (if different)				First name				M.I.	Social Security no.			
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Birthdate (MMDDYY)		Primary language (if different)								
PCP Last name				PCP First name				PCP no.		Current patient of PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Relationship: <input type="checkbox"/> Child <input type="checkbox"/> FT student** <input type="checkbox"/> Disabled child***												

*Marriage must have been entered into in a jurisdiction that recognizes its validity.

**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+.

4. OTHER COVERAGE INFORMATION**APPLICANT**

Do you currently have or have you had health insurance in the past 11 months?				<input type="checkbox"/> Yes <input type="checkbox"/> No (if no continue to Spouse/Dependent(s) section below)			
Has the coverage been continuous during the past 11 months?				<input type="checkbox"/> Yes <input type="checkbox"/> No		Coverage start date (MMDDYY)	
Will your current group insurance remain in effect after you enroll in this Empire plan?				<input type="checkbox"/> Yes <input type="checkbox"/> No		Coverage end date (MMDDYY)	
Name of other insurance carrier						Your ID no. from other carrier	
Coverage provided by employer?				<input type="checkbox"/> Yes <input type="checkbox"/> No		Employment status <input type="checkbox"/> Active <input type="checkbox"/> Retired	
Contract type: <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Individual <input type="checkbox"/> Parent/Child(ren)				Coverage type: <input type="checkbox"/> Hospital only <input type="checkbox"/> Hospital/Medical <input type="checkbox"/> Medical only <input type="checkbox"/> Other			

SPOUSE/DEPENDENT(S)

Does your spouse/dependent(s) currently have or have they had health insurance in the past 11 months?				<input type="checkbox"/> Yes <input type="checkbox"/> No (if no continue to section 5)			
Has the coverage been continuous during the past 11 months?				<input type="checkbox"/> Yes <input type="checkbox"/> No		Coverage start date (MMDDYY)	
Will their current group insurance remain in effect after you enroll in this Empire plan?				<input type="checkbox"/> Yes <input type="checkbox"/> No		Coverage end date (MMDDYY)	
<input type="checkbox"/> My spouse has or has had the same coverage as I. <i>Note: You do not need to fill out the rest of the spousal other coverage questions.</i> <input type="checkbox"/> My dependents have or have had the same coverage as I. <i>Note: You do not need to fill out the rest of the dependent other coverage questions.</i>							

SPOUSE

Name of Spouse's other insurance carrier						ID no.	
Coverage start date (MMDDYY)				Coverage end date (MMDDYY)			
Coverage provided by employer?				<input type="checkbox"/> Yes <input type="checkbox"/> No		Employment status <input type="checkbox"/> Active <input type="checkbox"/> Retired	
Contract type: <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Individual <input type="checkbox"/> Parent/Child(ren)				Coverage type: <input type="checkbox"/> Hospital only <input type="checkbox"/> Hospital/Medical <input type="checkbox"/> Medical only <input type="checkbox"/> Other			

DEPENDENT 1

Name of dependent's other insurance carrier						ID no.	
Coverage start date (MMDDYY)				Coverage end date (MMDDYY)			
Coverage provided by employer?				<input type="checkbox"/> Yes <input type="checkbox"/> No		Employment status <input type="checkbox"/> Active <input type="checkbox"/> Retired	
Contract type: <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Individual <input type="checkbox"/> Parent/Child(ren)				Coverage type: <input type="checkbox"/> Hospital only <input type="checkbox"/> Hospital/Medical <input type="checkbox"/> Medical only <input type="checkbox"/> Other			

DEPENDENT 2

Name of dependent's other insurance carrier												ID no.			
Coverage start date (MMDDYY)						Coverage end date (MMDDYY)									
Coverage provided by employer? <input type="checkbox"/> Yes <input type="checkbox"/> No						Employment status <input type="checkbox"/> Active <input type="checkbox"/> Retired									
Contract type: <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Parent/Child(ren)						Coverage type: <input type="checkbox"/> Hospital only <input type="checkbox"/> Hospital/Medical <input type="checkbox"/> Medical only <input type="checkbox"/> Other									

DEPENDENT 3

Name of dependent's other insurance carrier												ID no.			
Coverage start date (MMDDYY)						Coverage end date (MMDDYY)									
Coverage provided by employer? <input type="checkbox"/> Yes <input type="checkbox"/> No						Employment status <input type="checkbox"/> Active <input type="checkbox"/> Retired									
Contract type: <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Parent/Child(ren)						Coverage type: <input type="checkbox"/> Hospital only <input type="checkbox"/> Hospital/Medical <input type="checkbox"/> Medical only <input type="checkbox"/> Other									

5. MEDICARE INFORMATION (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.

Applicant last name						First name						M.I.		Medicare ID no.			
HIB Suffix						Part A Coverage start date (MMDDYY)						Part B Medical Coverage start date (MMDDYY)					
Spouse/Dependent's last name (if different)						First name						M.I.		Medicare ID no.			
HIB Suffix						Part A Coverage start date (MMDDYY)						Part B Medical Coverage start date (MMDDYY)					

6. EMPLOYER INFORMATION (THIS SECTION MUST BE FILLED IN BY YOUR GROUP BENEFITS ADMINISTRATOR.)

Group name												Group no.				Group Sub no.			
Address																			
City												State		ZIP code					
Employee no.						Payroll/Department location						Applicant's start date of full-time employment (MMDDYY)							

7. APPLICANT SIGNATURE (I HAVE READ THE CERTIFICATION AND FRAUD STATEMENT BELOW.)

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. 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 health care provider, health care 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 there to, 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 or each such violation.

Applicant signature

Print name

Date

Authorized Group Benefits Administrator signature

Print name

Date

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