

SECTION 4: APPLICANT AND FAMILY INFORMATION – Please list yourself and all eligible family members to be enrolled. Attach additional sheets if necessary.

Note: If you've chosen HMO/Direct HMO/Direct POS/Empire POS/DirectShare POS, 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.

APPLICANT				
Primary care physician (PCP) last name		Primary care physician (PCP) first name		PCP no.
				Current patient of PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No
Primary care dentist (PCD) last name		Primary care dentist (PCD) first name		PCD no.
				Current patient of PCD? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> SPOUSE <input type="checkbox"/> DOMESTIC PARTNER				
Last name		First name		M.I. Social Security no.
Sex <input type="checkbox"/> M <input type="checkbox"/> F	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
E-mail address (requested for ages 18 and over)				<input type="checkbox"/> Yes, information may be sent to me electronically.
DEPENDENT 1				
Last name		First name		M.I. Social Security no.
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Married? <input type="checkbox"/> Yes <input type="checkbox"/> No	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
E-mail address (requested for ages 18 and over)				<input type="checkbox"/> Yes, information may be sent to me electronically.
Relationship: <input type="checkbox"/> Child <input type="checkbox"/> Full-time student ⁵ <input type="checkbox"/> Disabled child ⁶ <input type="checkbox"/> Make available age 29 adult dependent child				
DEPENDENT 2				
Last name		First name		M.I. Social Security no.
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Married? <input type="checkbox"/> Yes <input type="checkbox"/> No	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
E-mail address (requested for ages 18 and over)				<input type="checkbox"/> Yes, information may be sent to me electronically.
Relationship: <input type="checkbox"/> Child <input type="checkbox"/> Full-time student ⁵ <input type="checkbox"/> Disabled child ⁶ <input type="checkbox"/> Make available age 29 adult dependent child				
DEPENDENT 3				
Last name		First name		M.I. Social Security no.
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Married? <input type="checkbox"/> Yes <input type="checkbox"/> No	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
E-mail address (requested for ages 18 and over)				<input type="checkbox"/> Yes, information may be sent to me electronically.
Relationship: <input type="checkbox"/> Child <input type="checkbox"/> Full-time student ⁵ <input type="checkbox"/> Disabled child ⁶ <input type="checkbox"/> Make available age 29 adult dependent child				

⁵ Child must exceed contractual dependent age and attend accredited college or university. Submit proof with this form. Proof is required annually.

⁶ Please submit Request for Disabled Child form (HAC506) with this form; child age must exceed contractual dependent age.

SECTION 5: OTHER COVERAGE INFORMATION – This section must be completed

Do you, or your family members, currently have, or have had, health insurance in the past 11 months?

Yes No If yes, please complete the following:

Name(s) of person(s) (first, M.I., last)	Insurance company information	Date coverage	Provided by employer?	Employment status	Contract type
Self	Name	Began	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Active <input type="checkbox"/> Retiree	<input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Parent/Child(ren)
	Phone	Ended			
	Certificate (policy no.)				
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	Name	Began	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Active <input type="checkbox"/> Retiree	<input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Parent/Child(ren)
	Phone	Ended			
	Certificate (policy no.)				
Dependent 1	Name	Began	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Active <input type="checkbox"/> Retiree	<input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Parent/Child(ren)
	Phone	Ended			
	Certificate (policy no.)				
Dependent 2	Name	Began	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Active <input type="checkbox"/> Retiree	<input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Parent/Child(ren)
	Phone	Ended			
	Certificate (policy no.)				
Dependent 3	Name	Began	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Active <input type="checkbox"/> Retiree	<input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Parent/Child(ren)
	Phone	Ended			
	Certificate (policy no.)				

SECTION 6: MEDICARE INFORMATION – For Medicare eligible only

Please provide a copy of the Medicare (HIB) card for each person listed below. If copies are not attached, we cannot process your Medicare benefits request.

APPLICANT

Medicare ID no.	HIB Suffix	Part A coverage start date	Part B coverage start date
-----------------	------------	----------------------------	----------------------------

SPOUSE

Medicare ID no.	HIB Suffix	Part A coverage start date	Part B coverage start date
-----------------	------------	----------------------------	----------------------------

DEPENDENT

Dependent name	Medicare ID no.	HIB Suffix	Part A coverage start date	Part B coverage start date
----------------	-----------------	------------	----------------------------	----------------------------

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.

SECTION 7: APPLICANT SIGNATURE – I have read the Certification and Insurance Fraud Statement below.

Certification: 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. The foregoing authorizations are valid for a maximum period of 24 months. If your Empire coverage remains in effect upon the expiration of 24 months from the date of this enrollment form, you will be required to reauthorize Empire or its designees to furnish all such records as described in this paragraph to the parties and for the purposes described in this paragraph for an additional authorization period. 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 X	Print name	Date (MMDDYY)
---------------------------------	------------	---------------

EMPLOYER INFORMATION (this section must be filled in by your group benefits administrator)

Group name	Group no.	Group sub no.
Street address	City	State ZIP code
Employee no.	Payroll/department location	Applicant's FT employment start date

Authorized Group Benefits Administrator signature X	Print name	Date (MMDDYY)
---	------------	---------------

This page intentionally left blank.