

NOTICE OF ELECTION FORM COMMUNITY GROUP

INSTRUCTIONS

Please complete in ink.

When you have completed your section "TO BE COMPLETED BY GROUP MEMBER," please give the form to your authorized group representative to complete the group section. If you are being added to an existing group, you must attach a copy of your pay stub as evidence of enrollment eligibility.

MEDICARE CARVEOUT COVERAGE

If you or your dependent is requesting Medicare Related/Carveout Coverage, you must attach a copy of the Red/White/Blue Medicare Insurance card for that person. (ii)

STATUS CHANGE

If you are requesting a status change, you need to do so no later than 30 days following the date of the event (i.e., marriage, divorce, death of spouse, dependent removal).

PORTABILITY OF COVERAGE

If you or your dependents have been covered by another insurer within the past 63 days, be sure to enclose proof of coverage. You may be eligible for credit toward completion of any applicable waiting period.

TYPE OF COVERAGE

The coverage you are selecting corresponds with the coverage option offered by your group and should be appropriate to your status.

TO BE CLASSIFIED AS:

AN INDIVIDUAL

- You are unmarried.
- You are married with no dependent children and your spouse is covered by Medicare as a primary carrier or another insurance carrier and he or she is not enrolling on this group. (i)

HUSBAND AND WIFE

- You are married with no dependent children.

PARENT & CHILD(ren)

- You are single with one (1) or more dependent child(ren).
- You are married with one (1) or more dependent child(ren) and a Medicare eligible spouse, who is not requesting medicare-related coverage or the spouse is covered by another insurance carrier. (i)

FAMILY

- You are married with a spouse and one or more dependent child(ren).

MEDICARE DISABLED

(Refer to item "F" on page 2).

(i) A Married applicant who is not enrolling his/her spouse because the spouse is covered by another carrier, including medicare, should submit evidence of the spouse's coverage.

(ii) TEFRA/DEFRA

Under the Medicare Secondary Payer provisions of the Social Security Act [42 U.S.C. Section 1395y(b)], employers with 20 or

more employees for 20 or more weeks a year (and small employers in multi-employer group health plans) are required to offer coverage to their active employees age 65 and older. Moreover, to the extent the employee has family coverage, employers must also offer coverage to Medicare eligible spouses (age 65 or older) regardless of the age of the employee. Where TEFRA/DEFRA is applicable family coverage may be obtained.

DEPENDENT CHILDREN: ELIGIBLE DEPENDENTS ARE THE NATURAL BORN OR LEGALLY ADOPTED CHILDREN OF THE HUSBAND OR WIFE AND ARE COVERED AS FOLLOWS:

- Until December 31st of the year in which the dependent child becomes age 19, as long as he or she remains unmarried, dependent upon the Husband or Wife for support, and is not a Full Time Student.
- A Full Time Student child dependent upon the Husband or Wife for support, is enrolled full time in an accredited institution of learning, and is eligible as dependent until December 31 of the year in which he or she becomes age 23, as long as he or she remains a Full Time Student.
- Proposed adoptive children until age 19 (or 23 if Full Time Students) who meet the other criteria described in this paragraph will be eligible based on proof of adoption.
- Disabled children over the age of 19 who meet the other criteria described in this paragraph may be eligible. See question 13, on page 3.
- If you are enrolling a dependent who is over 19 and is a full-time student at an accredited institution, evidence of full-time attendance must be submitted from that institution.

DEPENDENT DATA AND

PRIMARY CARE PHYSICIAN SELECTION

In this section, you must choose a Primary Care Physician (PCP) for yourself and each one of your dependents. Please refer to the Provider Directory for help in choosing a doctor. You may select one physician for the entire family or separate physicians for each family member. The name and code for the physician(s) you choose must be entered next to each member's name. If one physician is chosen for all family members, be sure to enter the physician's name and code separately next to each dependent.

Submit evidence from the institution of the student's attendance, with the notice of election. Children who marry, are no longer full time students, or are no longer dependent as a result of employment, are not eligible dependents.

Incomplete and unsigned election notices cannot be processed and could result in a delayed coverage effective date. Note: Be sure to read the Notice of Election carefully, including the statements on page 4 and include the Social Security Numbers of all dependents.

TO BE COMPLETED BY GROUP Please complete in ink.

Employee Name	No. of Hours Worked Per Week	Employee's Date of Full-Time Employment
Has employee ever been employed, part time? <input type="checkbox"/> Yes If Yes, give date(s) <input type="checkbox"/> NO		
Group Name	Signature of Authorized Group Benefits Administrator	
Group Address	Title	
City	State ZIP Code County	Date Signed

THIS REQUEST IS BEING SUBMITTED FOR:

- A.** New Employee – Evidence of employment must accompany notice of election (i.e. Pay stub, WT4b, payroll record etc.).
- Dependent of Employee Spouse Child (Meeting requirements for dependent coverage)
- B.** Employee (evidence of employment must accompany notice of election)
- Dependent, who did not apply when originally eligible reason for late enrollment _____

- C.** Employee requesting a status change (check reason)
- Married Divorced Widowed
- Dependent removal (explain) _____

Date of Event

MO	DAY	YR

- D.** A working employee over age 65 and/or the over age 65 dependent of a working employee (select one of the following)
- D-1 Elects the group health benefits as primary coverage to medicare (in accordance with TEFRA/DEFRA/COBRA legislation)
- D-2 Elects medicare related coverage. (This election is only available if the group employs less than 20 employees, in accordance with TEFRA/DEFRA/COBRA legislation)
- *If group employees more than 20 employees and an actively employed member or spouse of an actively employed member over age 65, elects medicare as primary coverage, no group coverage is available in accordance with TEFRA/DEFRA/COBRA legislation.

- E.** A covered retiree for whom the group offers coverage and contributes to the cost of coverage and the dependent(s) of a group covered retiree. (Proof of former employment may be requested). (Check the appropriate boxes below)
- Under age 65 (only the group's health benefits program is available).
- Over age 65 (only medicare-related coverage is available)

State Retirement Date

MO	DAY	YR

- F.** Medically Disabled, Medicare-Eligible, Active Employee and/or the Medically Disabled, Medicare-Eligible Dependent of an Active Employee.
- Elects group health benefits as primary (in accordance with OBRA legislation if greater than 100 employed by group)
- Elects Medicare related coverage (in accordance with OBRA legislation if less than 100 employed by group)

*If the employee or dependent is eligible for Medicare coverage due to end stage renal disease, coverage must be selected based on fulfillment of the Medicare coordination period (in accordance with OBRA/COBRA regulations)

End Stage Renal Disease? Yes No

Medicare Entitlement Date

MO	DAY	YR

- G.** A former employee and/or dependent who elects to continue coverage under the group's health benefits program (in accordance with COBRA legislation or the New York State continuation of coverage regulations) complete appropriate boxes below

- COBRA NYS Former Employee Spouse Dependent Child

Nature of Qualifying Event: _____

Qualifying Event Date

MO	DAY	YR

NOTE: A copy of the RED/WHITE/BLUE Medicare card must accompany this notice of election when Medicare related coverage is elected. If the card has not been received a letter from the Social Security Administration is required

Please provide the following information. (If this is a new group, this section will be completed by Empire HealthChoice HMO, Inc.)

GROUP NUMBER	SUB-DIVISION	EFFECTIVE DATE

TO BE COMPLETED BY GROUP MEMBER Please complete in ink.

1. Social Security Number			Home Phone No.	Day Phone No.
2. Last Name			First Name	MI
3. Home Address			In Care Of	APT No.
4. City	State	Zip Code	5. County	<input type="checkbox"/> Single <input type="checkbox"/> Married
7. Occupation	8. Type of Coverage (check coverage requested) A) <input type="checkbox"/> HMO <input type="checkbox"/> Direct HMO <input type="checkbox"/> Dental (If offered by Group)		6. Date of Marriage 8A. Type of Coverage <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Employee/Spouse B) <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Medicare Related / Carveout Coverage	

MANDATORY TO FILL OUT

PORTABILITY OF COVERAGE

If you or your dependent(s) were covered by another insurance carrier within sixty three (63) days of the effective date of this contract you may be eligible for credit toward completion of any applicable waiting period, for the time enrolled with that carrier. To determine eligibility for this credit, a certificate of group health coverage, letter of proof from your prior carrier or any reasonable substantiation of prior coverage is required. This must contain name, contract type, level of benefits and period of enrollment.

COORDINATION OF BENEFITS

<p>9. Member Information Are you currently covered by another health plan? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, will that coverage be terminated upon issuance of this coverage? Yes <input type="checkbox"/> No <input type="checkbox"/> If not currently covered by another carrier, were you covered within the past 63 days? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>9A. Name, Address, Telephone Number of other Carrier _____ _____ _____</p> <p>9B. Your Identification Number with other carrier _____</p> <p>9C. Effective Date _____ Termination Date _____</p> <p>9D. Contract Type <input type="checkbox"/> Group <input type="checkbox"/> Non-Group <input type="checkbox"/> Individual <input type="checkbox"/> Husband/Wife <input type="checkbox"/> Parent/Child(ren) <input type="checkbox"/> Family</p> <p>9E. Was coverage provided by employer? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of employer _____ Currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No Retired? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9F. Coverage Type, check all that apply <input type="checkbox"/> Hospital <input type="checkbox"/> Medical <input type="checkbox"/> Other (Specify) _____ If Yes, Complete 12A.</p>	<p>10. Spouse/Dependent Information Is (was) your spouse/dependent covered by another health plan? other than described in No. 9? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, will that coverage be terminated upon issuance of this coverage? Yes <input type="checkbox"/> No <input type="checkbox"/> If not currently covered by another carrier, was spouse/dependent covered within the past 63 days? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>10A. Name, Address, Telephone Number of other Carrier _____ _____ _____</p> <p>10B. Spouse/Dependent name and identification number with other carrier _____ _____ _____</p> <p>10C. Effective Date _____ Termination Date _____</p> <p>10D. Contract Type <input type="checkbox"/> Group <input type="checkbox"/> Non-Group <input type="checkbox"/> Individual <input type="checkbox"/> Husband/Wife <input type="checkbox"/> Parent/Child(ren) <input type="checkbox"/> Family</p> <p>10E. Was coverage provided by employer? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of employer _____ Currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No Retired? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10F. Coverage Type, check all that apply <input type="checkbox"/> Hospital <input type="checkbox"/> Medical <input type="checkbox"/> Other (Specify) _____</p>
<p>11. If any family member listed on this application is currently enrolled with Empire, that coverage will be cancelled and membership will be transferred to the coverage requested here unless so indicated, and the reason described below is approved by Empire. <input type="checkbox"/> DO NOT TRANSFER Reason: _____</p>	
<p>12. Is spouse currently employed 20 hours per week, or more? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Complete 12A.</p>	<p>12A. Name and address of spouse's employer _____</p>
<p>13. Do you or your spouse have an over age dependent child who is mentally challenged, or mentally ill, physically handicapped or developmentally disabled for whom coverage is being requested under this family plan? <input type="checkbox"/> Yes <input type="checkbox"/> No. If yes, a separate enrollment form (HAC 506) must be submitted to determine the dependent's eligibility under the family coverage. Name of Dependent _____ Date of Birth _____</p>	

MEDICARE

14. If the employee or a dependent is medicare eligible, the following must be completed as shown on the person's red/white/blue medicare card.
 (Copy of H.I.B. card MUST be submitted.)

Name of Medicare Eligible Person	Effective Date		Medicare Identification No.	HIB Suffix
	Hospital	Medical		

DEPENDENT DATA AND PRIMARY CARE PHYSICIAN SELECTION

15. List below your name and the name(s) of eligible dependent(s) to be covered, including spouse and dependent children (check with your group's benefit administrator to verify age limits for dependent coverage). Select a primary care physician for yourself and your dependents.

First	MI	Last (If Different)	Birthdate M/D/Y	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship <input type="checkbox"/> Self	Social Security Number	PCP Name _____ PCP NO.	Current PCP <input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> FT Student <input type="checkbox"/> Dom.Partner		_____ PCP NO.	<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> FT Student <input type="checkbox"/> Dom.Partner		_____ PCP NO.	<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> FT Student <input type="checkbox"/> Dom.Partner		_____ PCP NO.	<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> FT Student <input type="checkbox"/> Dom.Partner		_____ PCP NO.	<input type="checkbox"/> YES <input type="checkbox"/> NO

16. Please indicate your primary language:

****SEE INSTRUCTIONS REGARDING FULL TIME STUDENTS OVER AGE 19 YEARS. SUBMIT EVIDENCE WITH ENROLLMENT.**

BASIC COVERAGE AGREEMENT

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 myself and all eligible dependents. I understand that I am under a continuing obligation to notify the group of a change in my, or my dependents' status. That 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 understand that in-network benefits will be available only if I, or my dependents, receive covered services provided or authorized by the primary care physician. Otherwise, no out-of-network benefits will be available, unless specifically stated otherwise in the contract. If this contract or group plan is direct connection hmo, no referrals are required by the PCP.

I understand that if I become medicare eligible while I am covered under this contract, that 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.

I authorize any health care provider, payor of health and health related claims, 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 review and evaluation of any claim, or services in conjunction with managed care. I also authorize empire to disclose such information to my PCP and other network physician(s), to another payor or self-insurer and to the group contract holder or an Empire designee for purposes of continuity of care and medical management, disease management, managed disability coordination or financial audits. This authorization shall become effective immediately, and shall remain in effect for six years after the termination of the coverage, or the last determination or payment by empire on a claim or service under the coverage, whichever is latest. This authorization shall be binding upon me, my dependents, my heirs, executors, or administrators.

If this notice of election is accepted, benefits under certificates issued will be available from the effective date, if payment is received before that date. If group has less than 51 employees, that coverage for pre-existing conditions will be excluded for 11 months from the effective date. (Credit will be provided toward the waiting period under this contract or group plan for the time I was covered under another contract or group plan which provided substantially similar benefits if there was no break in coverage greater than 63 days between the termination of the other coverage and the effective date of coverage under this contract or group plan. If the benefits of the previous coverage are not substantially similar, credit will be provided only as to those benefits covered under both the previous coverage and this contract or group plan.)

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 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 material 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.

Applicant's Signature (Do Not Print)			Date Signed
Spouse's Signature, if applying for family coverage (Do Not Print)			Date Signed
FOR OFFICE USE ONLY	Effective Date	Division No.	County
	Rate Package	Tier	
Region			