

**New York
Small Group Employee Enrollment Application
For Groups of 1-100¹ (Medical/Vision)
For Groups of 1-50 (Dental)**



An Anthem Company

You, the employee, must complete this application. You are solely responsible for its accuracy and completeness.
To avoid the possibility of delay, answer all questions and be sure to sign and date your application.

Please complete in black ink only.

Section A: Employee Information					
Last name		First name		M.I.	Social Security no. ² (required)
Home address – Street and PO Box if applicable					
City			County		State ZIP code
Primary phone no.		Secondary phone no.		Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner	
Marriage date (MM/DD/YYYY)					
Employee email address					
Employer name					Group no. (if known)
Employer street address					
City					State ZIP code
Employment status <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Retired		Date of hire (MM/DD/YYYY)	Date of full-time employment (MM/DD/YYYY)	Date waiting period begins (MM/DD/YYYY)	No. of hours worked per week
Language choice (optional): <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> Other – please specify: _____					
Do you read and write English? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, the translator must sign and submit a Statement of Accountability					
Section B: Application Type					
Select one					
<input type="checkbox"/> New enrollment		<input type="checkbox"/> COBRA –		Qualifying event date	
<input type="checkbox"/> Open enrollment		Select qualifying event		_____	
<input type="checkbox"/> Rehire		<input type="checkbox"/> Left employment		<input type="checkbox"/> Reduction in hours	
		<input type="checkbox"/> Loss of dependent child status		<input type="checkbox"/> Divorce or legal separation	
		<input type="checkbox"/> Medicare		<input type="checkbox"/> Covered employee's Medicare entitlement	
<input type="checkbox"/> Mandatory Right of Election to continue Dependent coverage through age 29 (Qualified dependents only)					

1 A small group must have at least one active full-time equivalent employee that meets the definition of employee in 42 U.S.C. 300gg-91(d)(5) but no more than 100 employees. A small group can consist of one non-spouse employee plus the business owner; a group of 100 would consist of the business owner plus 99 employees. Healthy New York coverage is only available for groups 1-50.

2 Empire is required by the Internal Revenue Service to collect this information.

Social Security no.

Section C: Type of Coverage

1. Medical Coverage – select one plan option

All medical plans include pediatric dental coverage (up to age 19).

Member medical coverage – select one:
 Employee only Employee + Spouse/Domestic Partner Employee + child(ren) Family No coverage

Please indicate the contract code for the medical plan selected. Contract code: _____

2. Dental Coverage – Please ask your employer which dental options are available before checking your selection.

Empire Family Dental and Empire Family Dental Enhanced plans include pediatric dental essential health benefits. All other plans including Empire Dental Prime and Complete with product families including Value, Classic, Enhanced, and Voluntary do not include pediatric dental essential health benefits. Your employer will advise you of your plan options. Please list below the contract code for the dental plan you select.

Member dental coverage – select one:
 Employee only Employee + Spouse/Domestic Partner Employee + child(ren) Family No coverage
 If waiving coverage for employee and/or any eligible family members, you must complete Section F.

Dental contract code – Please indicate the contract code for the dental plan chosen. Your employer will advise you of your plan options and contract codes.
 Contract code: _____

3. Vision Coverage – select one plan option

Member vision coverage – select one:
 Employee only Employee + Spouse/Domestic Partner Employee + child(ren) Family No coverage
 If waiving coverage for employee and/or any eligible family members, you must complete Section F.

Vision contract code – Please indicate the contract code for the vision plan selected. Your employer will advise you of your plan options and contract codes.
 Contract code: _____

Social Security no. _____

Section D: Coverage Information – All fields required. Attach a separate sheet if necessary.

Dependent information must be completed for any dependents to be covered. An eligible dependent may be your spouse/domestic partner (if this option is chosen by your employer), your children, or your spouse's children (or domestic partner's children if applicable). Dependent coverage will continue to the end of the calendar month in which the dependent turns age 26 unless:

- he or she qualifies as a disabled person, *If Dependent is over age disabled, please complete the Handicap/Dependent Form (HAC 506). You can find this form at http://www.empireblue.com/wps/portal/ehpemployer?content_path=employer/nowapplication/f4/s3/t0/pw_ad067515.htm&rootLevel=3&label=Forms, or
- your employer has chosen extended dependent coverage for adult dependents through age 29 and your dependent qualifies, or
- you or the dependent have purchased a rider to extend coverage for young adults through age 29 and your dependent is eligible.

List all dependents below beginning with the eldest.

Employee Last name		First name	M.I.	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Birthdate (MM/DD/YYYY)	Relationship to applicant Self			
Name of PCP you choose from our Pathway HMO/Small Group Provider Network ¹			PCP ID no.	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

Spouse/Domestic Partner Last name		First name	M.I.	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Birthdate (MM/DD/YYYY)	Social Security no. ² (required)	Relationship to applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner		
Name of PCP you choose from our Pathway HMO/Small Group Provider Network ¹			PCP ID no.	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

Dependent Last name		First name	M.I.	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Birthdate (MM/DD/YYYY)	Social Security no. ² (required)	Relationship to applicant <input type="checkbox"/> Child <input type="checkbox"/> Make available age 29 adult dependent child (rider provided by your employer) <input type="checkbox"/> Age 29 adult dependent child (rider purchased separately by you or the dependent) <input type="checkbox"/> Other If other, what is relationship? _____		
Name of PCP you choose from our Pathway HMO/Small Group Provider Network ¹			PCP ID no.	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does this dependent have a different address? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please enter: _____				

Dependent Last name		First name	M.I.	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Birthdate (MM/DD/YYYY)	Social Security no. ² (required)	Relationship to applicant <input type="checkbox"/> Child <input type="checkbox"/> Make available age 29 adult dependent child (rider provided by your employer) <input type="checkbox"/> Age 29 adult dependent child (rider purchased separately by you or the dependent) <input type="checkbox"/> Other If other, what is relationship? _____		
Name of PCP you choose from our Pathway HMO/Small Group Provider Network ¹			PCP ID no.	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does this dependent have a different address? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please enter: _____				

Dependent Last name		First name	M.I.	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Birthdate (MM/DD/YYYY)	Social Security no. ² (required)	Relationship to applicant <input type="checkbox"/> Child <input type="checkbox"/> Make available age 29 adult dependent child (rider provided by your employer) <input type="checkbox"/> Age 29 adult dependent child (rider purchased separately by you or the dependent) <input type="checkbox"/> Other If other, what is relationship? _____		
Name of PCP you choose from our Pathway HMO/Small Group Provider Network ¹			PCP ID no.	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does this dependent have a different address? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please enter: _____				

1 To view our Pathway HMO/Small Group provider network, please log into Empireblue.com and look for "Find a Doctor" under "Useful Tools." To request a paper copy, please call your Broker or Empire representative.

2 Empire is required by the Internal Revenue Service to collect this information.

Social Security no. _____

Section E: Other Group Coverage

Are you or anyone applying for coverage currently eligible for Medicare?
 Yes No
 If yes, give name: _____

Medicare ID no.	Medicare Part A effective date	Medicare Part B effective date	Medicare eligibility reason (check all that apply) <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ESRD: Onset date: _____
Medicare Part D ID no.	Medicare Part D Carrier		Medicare Part D effective date

On the day your coverage begins, will you or a family member be covered by Medicare?
 Yes No
 On the day your coverage begins, will you or a family member be covered by other health coverage?
 Yes No
 On the day your coverage begins, will you or a family member be covered by other dental coverage?
 Yes No

If yes to any of these questions, please provide the following:

Name of person covered (Last name, first, M.I.)	Type (check one)	Coverage (check all that apply)	Carrier name	Carrier phone no.	Policy ID no.	Dates (if applicable)
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental				Start: _____ End: _____
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental				Start: _____ End: _____
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental				Start: _____ End: _____
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental				Start: _____ End: _____
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental				Start: _____ End: _____

Section F: Waiver/Declining Coverage

Medical coverage declined for – check all that apply: Myself Spouse/Domestic Partner Dependent(s)
Dental coverage declined for – check all that apply: Myself Spouse/Domestic Partner Dependent(s)
Vision coverage declined for – check all that apply: Myself Spouse/Domestic Partner Dependent(s)

Sign here only if you are declining coverage.

Signature of applicant X	Printed name	Date (MM/DD/YYYY)
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Section G: Terms, Conditions and Authorizations

Please read this section carefully before signing the application.

Eligible employee:

- An employee of the Employer who works the number of hours per week to be eligible for benefits as defined by the Employer, who meets the definition of “employee” under New York State and Federal laws, and is approved by Empire as of the effective date. Employment must be verifiable from a current payroll listing or state or federal wage tax reports.
- An employee, as defined above, who enters into employment after the coverage effective date and who completes the group imposed waiting period for eligibility (if any) and applies for coverage within 45 days.
- Any other class of persons identified by the Employer, provided that written approval of their eligibility is obtained from the Company(ies); or
- Employees eligible for continued coverage under New York State or federal laws.

Eligible employee does not include consultants and independent contractors (1099 employees), temporary workers, directors and officers who do not qualify as owners, partners or employees, union members covered by a union-sponsored health plan, unless they meet the definition of “employee” under New York State and Federal laws.

Eligible dependent:

- Employee’s spouse, or children age 26 or younger, which includes a newborn, natural child, or a child placed with the employee for adoption, a stepchild or any other child for whom the employee has legal guardianship or court ordered custody. The age limit for coverage of a child is (1) age 26 unless the employer has chosen extended dependent coverage and the dependent qualifies, (2) or you or the dependent have purchased a rider to extend coverage for young adults through age 29 and your dependent is eligible. In the case of (1) or (2), the dependent the age limit for coverage is age 30. Coverage for children will end on the last day of the month in which the children reach age 26, or age 30 if applicable.
- The contract age limit does not apply for initial or continued enrollment of an unmarried child who is incapable of self-sustaining employment because of mental illness, developmental disability, or mental retardation (as defined in the NYS mental hygiene law), or physical handicap. In order for the extended eligibility to apply, the child must have been in the incapacitated condition before s/he reached the age limit at which coverage would otherwise end under the benefit plan. The child must be chiefly dependent on the member for support and maintenance and must remain in the incapacitated condition to remain eligible. The member must submit proof of the child’s incapacity within 31 days of the date the child reaches the termination age that would otherwise apply. (The employee will be asked to provide a physician’s certification (HAC 506) of the dependent’s condition.)
- Dependents eligible for continued coverage under New York State or federal laws.

For Health Savings Account enrollees: Except as otherwise provided in any agreement between me and the financial custodian, the custodian of my Health Savings Account (HSA), I understand that my authorization is required before the financial custodian may provide Empire with information regarding my HSA. I hereby authorize the financial custodian to provide Empire with information about my HSA, including account number, account balance and information regarding account activity. I also understand that I may provide Empire with a written request to revoke my authorization at any time.

In signing this application I represent that:

I certify each Social Security number listed on this application is correct.

By signing below, I (primary applicant) agree to receive my plan-related communications either by email or electronically. This may include my certificate, evidence of coverage, explanation of benefits statements, required notices or helpful information to get the most out of my plan. I agree to provide and update Empire with my current email address. I know that at any time I can change my mind and request a copy of these materials (or any specific materials) by mail, by contacting Empire.

As an eligible employee, I am requesting coverage for myself and all eligible dependents listed and authorize my employer to deduct any required contributions for this insurance from my earnings. I understand all benefits are subject to conditions stated in the Group Contract and coverage document.

I have read or have had read to me the completed application, and I realize any false statement or misrepresentation in the application may result in loss 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 fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Sign here	Applicant signature 	Date (MM/DD/YYYY)
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