EmblemHealth®

# TRANSACTION FORM FOR GROUP ACCOUNTS

## I. SUBSCRIBER INFORMATION

| Last Name | First Name | M.I. | Sex | Social Security Number |
|---|---|---|---|---|
| | | | | ___-___-____ |

| Street Address | Apt. | City | State | ZIP Code |
|---|---|---|---|---|
| | | | | |

**Were you ever a member of EmblemHealth?**
☐ NO ☐ YES
If YES, member ID _____

**Marital Status:**
☐ Single ☐ Married
☐ Domestic Partner

**Birth Date:** Mo. | Day | Yr.

Telephone #:
Home: (_____) _____
Work: (_____) _____

E-Mail Address: _____
☐ "**GO PAPERLESS" and save trees (see back of application)***

Young Adult Coverage: ☐ 26 And Under — Family ☐ 26 - 29 — Single Parent ID: _____

Subscriber Employment Status: _____
☐ Applicant working at least 20 hours per week

**Disabled?** ☐ NO ☐ YES

**Primary Care Physician Name:** (Not required for EPO/PPO members)
_____
ID Number: _____

**OB/GYN Selection Name:** (Optional)
_____
ID Number: _____

**Prior Health Insurance Information:**
Carrier Name: _____
Coverage Begin Date: ____ / ____ / ____
Coverage End Date: ____ / ____ / ____

**Are you covered by any other health insurance or Medicare?**
☐ NO ☐ YES If YES, indicate:
Insurance Co. Name: _____
Insurance Co. Telephone #: (_____) _____ Type of Coverage: _____
Policy #: _____ Effective Date: ____ / ____ / ____

**Check One:**
☐ New Enrollment
☐ Reinstatement
☐ Termination
☐ Change to Ind.

**Status:**
☐ Add Dependent
☐ Remove Dep.
☐ Address Change
☐ Name Change

**Transfer:**
☐ To Another Carrier
☐ EmblemHealth Group Change:
From: _____
To: _____

## II. ENROLLMENT INFORMATION — IF YOU ARE ENROLLING YOUR SPOUSE/DP AND/OR CHILDREN, PLEASE LIST EACH ONE BELOW — SEE ELECTION OF COVERAGE FOR ELIGIBILITY

| Last Name (if different) | First Name | Social Security Number | Sex | Relationship | Birth Date Mo. | Day | Yr. | ✓ if Disabled | Primary Care Physician Name/ID Number (Not required for EPO/PPO members) | OB/GYN Selection Name/ID Number (Optional) |
|---|---|---|---|---|---|---|---|---|---|---|
| DEPENDENT | | ___-___-____ | | ☐ Spouse ☐ DP ☐ Child | | | | | | |
| Current/Prior Health Insurance Information: | Carrier Name: _____ | | | Coverage Begin Date: ____ / ____ / ____ | Coverage End Date: ____ / ____ / ____ | | | | | |
| DEPENDENT | | ___-___-____ | | ☐ Child | | | | | | |
| Current/Prior Health Insurance Information: | Carrier Name: _____ | | | Coverage Begin Date: ____ / ____ / ____ | Coverage End Date: ____ / ____ / ____ | | | | | |
| DEPENDENT | | ___-___-____ | | ☐ Child | | | | | | |
| Current/Prior Health Insurance Information: | Carrier Name: _____ | | | Coverage Begin Date: ____ / ____ / ____ | Coverage End Date: ____ / ____ / ____ | | | | | |

**Note:** A birth/marriage certificate or 1040 Form will be required for spouse/dependents with different last name.

**Your signature is required to process this form. Your signature attests that you have read the reverse side of this form.**

**Applicant must sign here:** _____ **Date:** _____ / _____ / _____

## III. EMPLOYER INFORMATION — THIS SECTION TO BE COMPLETED BY EMPLOYER/CONTRACTOR GROUP

| Name of Group: | Group Number: | | |
|---|---|---|---|
| Middle Country CSD | 1007267000 | ☑ EmblemHealth ☐ GHI ☐ GHI HMO ☐ HIP<br>Plan Name: _____ | **Type of Coverage:** ☐ Individual ☐ Family ☐ Employee & Spouse/DP ☐ Employee & Child |

| Requested Effective Date: | Hire Date: | Waiting Period: | Date Submitted: | Approved By: (Group Plan Administrator) |
|---|---|---|---|---|
| Medical: ____ / ____ / ____ Dental: ____ / ____ / ____ | | | | |

Instructions to Benefit Administrators or Group Representatives: For groups with 50 employees or fewer, you MUST complete Section A on the reverse side of this form. Required documentation MUST be attached to this Transaction Form to be processed.

# ELECTION OF COVERAGE

**Pre-existing conditions will not be covered during the first 12 months of enrollment in the EmblemHealth CompreHealth program or during the first 11 months of enrollment in the EmblemHealth EPO, EmblemHealth PPO, EmblemHealth ConsumerDirect PPO or EmblemHealth ConsumerDirect EPO plans. For policies issued or renewed after September 23, 2010, pre-existing condition limitations will be waived for enrollees under age 19. A pre-existing condition is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice of treatment was recommended or received during the six-month period prior to your enrollment date. EmblemHealth will credit the time you were covered by prior creditable health insurance coverage toward the 12-month or 11-month period, as long as the break in coverage between the prior coverage and your EmblemHealth coverage does not exceed 63 days, exclusive of any waiting periods. If requested, you or your group must provide EmblemHealth with information about your pre-existing conditions and/or previous coverage. You have the right to request a Certificate of Creditable Coverage from your prior health plan. If needed, EmblemHealth will help you get such a certificate from your prior plan.**

**A large group (51 or more eligible employees) may elect to cover pre-existing conditions from the start of your EmblemHealth coverage. In such a case, your EmblemHealth policy will not contain a pre-existing condition limitation or it will state that the pre-existing condition limitation does not apply.**

**Please call EmblemHealth at 1-877-842-3625 for more information about a pre-existing condition limitation.**

## IMPORTANT INFORMATION

1. The subscriber must complete sections I and II. The group plan administrator must complete section III and if for a small group (50 employees or fewer), provide all necessary documentation.
2. All transactions are subject to EmblemHealth's retroactive policy (30 days for small groups, 90 days for large groups).
3. For policies issued or renewed after September 23, 2010, dependent children may stay on or be added to a parent's policy until age 26 (end of birthday month), regardless of student status, as part of federal health reform. The premium will be billed at the applicable coverage tier and, other than the basic enrollment form, nothing else is required. Most employer groups cannot limit dependent coverage eligibility even if the qualified dependent has access to his or her own employer-based coverage. Only standard GHI and HIP HMO Direct Pay, Healthy New York and GHI large groups have the possibility of restrictions for adding dependents up to age 26. As part of New York State's "age 29" law, eligible young adults through age 29 (up to 30th birthday) may continue or obtain coverage through a parent's group policy.
4. Failure to complete any part of this form (e.g., group number, reason for submission, certificate number, signature, etc.) will require EmblemHealth to return this transaction form to the employer group plan administrator and may delay the requested effective date of coverage.

Effective September 23, 2010, federal health reform may require changes to your coverage, depending on your plan. Get more information at **www.emblemhealthreform.com**.

*** By electing "Go Paperless," you will receive claim statements and some other EmblemHealth letters by e-mail instead of paper mail. You will be able to view your Explanation of Benefits (EOBs) under the Claims section of the EmblemHealth Web site. Your enrollment in the "Go Paperless" option will continue as long as your account remains active, or until you choose to discontinue this option.**

## SECTION A

(To be completed by Benefits Administrator)

## DOCUMENTATION BASED ON GROUP SIZE

| ACTION Check (✔)One | Qualifying Event | Documentation Required | Group Type (Check One) → ☐ Sole Proprietorship or One-Subscriber Group | ☐ Association of Two or More Employees | ☐ Small Group — Less than 50 Employees |
|---|---|---|---|---|---|
| ☐ Add Subscriber | New Hire or Change in Plan | For eligible employees who work more than 20 hours weekly, provide a recent Copy of NYS45 showing this subscriber as an employee or provide copy of payroll documentation reflecting the date, employee's name and Social Security #, or the employee's current-year W4 form. | Not Eligible | | |
| ☐ Add Spouse | Marriage | **If last name is different**<br>☐ Marriage Certificate<br>☐ 1040 Form | | | |
| ☐ Add Dependent | Birth<br>Adoption | **If last name is different**<br>☐ Birth Certificate<br>☐ Formal Adoption Papers<br>☐ Court Approved Guardianship Papers | | | |
| ☐ Add Spouse<br>☐ Add Dependent | Loss of Coverage | Certificate of Creditable Coverage | | | |
| ☐ Add Domestic Partner | Domestic Partnership | Declaration of Cohabitation & Financial Interdependence form | Not Eligible | Not Eligible | |

**Note: No Retroactive Enrollments will be allowed. Members must be enrolled within 30 days from the Qualifying Event/next billing date.**

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