



# ENROLLMENT/CHANGE FORM

Thank you for choosing Empire. Please fill out all items in order for us to quickly and accurately process your enrollment. Make sure you use **blue or black ink only, fill in circles completely, print in capital letters, and stay within the boxes when writing.** Once you've completed this form, please sign in the space provided in Section 8.

PO Box 1407, Church Street Station  
New York, NY 10008-1407  
www.empireblue.com

## 1. REASON FOR ENROLLMENT/CHANGE Complete section A, B or C.

### A. New Enrollment/Addition (fill in one circle only)

**New Hire** 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.

**Open Enrollment**

**Status Change** (fill in one circle below) **Date of Change (MMDDYY)**

Marriage

Adoption

Newborn

Retirement

Medicare Eligible (answer questions below)

Eligibility criteria (fill in one circle only)  Age 65+  Disability  End Stage Renal Disease

Active employee?  Yes  No

Electing company coverage as primary coverage?  Yes  No

Electing Medicare-related coverage as primary coverage?  Yes  No  
(If company size is under 20 employees and end stage renal disease does not apply, you must choose this option)

Part-Time to Full-Time

COBRA/NYS Continuation of Coverage

Nature of COBRA/  
NYS Event:

Other:

### B. Change (fill in all circles that apply)

For all circles filled in below, please supply new information in Section 4.

Name

Address

HMO/Direct HMO Primary Care Physician (PCP)

Managed Dental Primary Care Dentist (PCD)  
If your company offers an Empire Dental plan

### C. Cancel Coverage (fill in one circle 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 circle below and enter the name in the Spouse/Dependent portion in Section 4.

#### Spouse/Dependent

Death

Divorce

Dependent no longer eligible

Other:

#### Date of Event (MMDDYY)

## 2. BENEFITS SELECTION

**Medical Insurance** (fill in one circle only)  PPO  EPO<sup>‡</sup>  HMO  Direct HMO Indemnity:  Hospital/Medical or  Hospital Only  Other

**Coverage Type** (fill in one circle only)  Individual  Husband/Wife  Parent/Child(ren)  Family

**Dental Insurance<sup>†</sup>** (fill in one circle only)  PPO Dental  Managed Dental  Voluntary Dental  Other Dental

**Coverage Type** (fill in one circle only)  Individual  Husband/Wife  Parent/Child(ren)  Family

<sup>‡</sup>EPO benefits provided by Empire HealthChoice Assurance, Inc.

<sup>†</sup>If your company offers an Empire Dental plan

## 3. CUSTOMER SERVICE SELECTION activate at www.empireblue.com

Fill in all the circles of the following telephone and Internet services you wish to use:

I want a **secure, personalized website** at www.empireblue.com. Send my activation information to my E-mail address in Section 4.

Whenever possible, send my plan information to me through www.empireblue.com instead of the mail.

I plan to continue using **1-800 numbers** to call customer service.

## 4. APPLICANT AND SPOUSE/DEPENDENT INFORMATION

Note: If you've chosen HMO/Direct HMO, 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

MI

Social Security Number

Gender

Birth Date (MMDDYY)

Marital Status

Date of Marriage (MMDDYY)

M  F

Married  Single

E-mail Address

Applicant

ENR0296P1

Empire HealthChoice, Inc. operates under the trade name of Empire BlueCross BlueShield. Empire HealthChoice, Inc. and Empire HealthChoice Assurance, Inc. are licensees of the Blue Cross and Blue Shield Association, an Association of independent Blue Cross and Blue Shield Plans.

#### 4. APPLICANT AND SPOUSE/DEPENDENT INFORMATION (continued)

Applicant (cont.)

Home Phone

Daytime Phone

Home Address

Apt. No.

City

State

Zip

Occupation

Primary Language

PCP Last Name

PCP First Name

PCP Number

Current Patient of PCP?

 Y  N

Primary Care Dentist (PCD) Last Name

PCD First Name

PCD Number

Current Patient of PCD?

 Y  N

Spouse

Social Security Number

Birth Date (MMDDYY)

Gender

 M  F

Primary Language (if different)

Last Name (if different)

First Name

MI

PCP Last Name

PCP First Name

PCP No.

Current Patient of PCP?

 Y  N

Dependent 1

Social Security Number

Birth Date (MMDDYY)

Gender

 M  F

Primary Language (if different)

Last Name (if different)

First Name

MI

PCP Last Name

PCP First Name

PCP No.

Current Patient of PCP?

 Y  N

Relationship:  Child  FT Student<sup>¥</sup>  Disabled Child<sup>§</sup>

Dependent 2

Social Security Number

Birth Date (MMDDYY)

Gender

 M  F

Primary Language (if different)

Last Name (if different)

First Name

MI

PCP Last Name

PCP First Name

PCP No.

Current Patient of PCP?

 Y  N

Relationship:  Child  FT Student<sup>¥</sup>  Disabled Child<sup>§</sup>

Dependent 3

Social Security Number

Birth Date (MMDDYY)

Gender

 M  F

Primary Language (if different)

Last Name (if different)

First Name

MI

PCP Last Name

PCP First Name

PCP No.

Current Patient of PCP?

 Y  N

Relationship:  Child  FT Student<sup>¥</sup>  Disabled Child<sup>§</sup>

<sup>¥</sup> Must be age 19+ and attend accredited college or university. Submit proof with this form. Proof is required annually.

<sup>§</sup> Please submit Request for Disabled Child form (HAC506) with this form; child must be age 19+.



**6. 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, 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.

Applicant Last Name										First Name										MI	
<input type="text"/>										<input type="text"/>										<input type="text"/>	
Medicare ID Number								HIB Suffix		Part A Hospital Coverage Start Date (MMDDYY)				Part B Medical Coverage End Date (MMDDYY)							
<input type="text"/>								<input type="text"/>		<input type="text"/>				<input type="text"/>							
Spouse/Dependent's Last Name (if different)										First Name										MI	
<input type="text"/>										<input type="text"/>										<input type="text"/>	
Medicare ID Number								HIB Suffix		Part A Hospital Coverage Start Date (MMDDYY)				Part B Medical Coverage End Date (MMDDYY)							
<input type="text"/>								<input type="text"/>		<input type="text"/>				<input type="text"/>							

**7. EMPLOYER INFORMATION** This section must be filled in by your Group Benefits Administrator.

Group Name																													
<input type="text"/>																													
Address																													
<input type="text"/>																													
City															State			Zip											
<input type="text"/>															<input type="text"/>			<input type="text"/>											
Applicant's Start Date of Full Time Employment (MMDDYY)										Payroll/Department Location										Employee Number									
<input type="text"/>										<input type="text"/>										<input type="text"/>									
Group Number					Group Sub Number																								
<input type="text"/>					<input type="text"/>																								

**8. SIGNATURES** I have read the certification and fraud statement below.

Applicant Signature															Date (MMDDYY)				
<input type="text"/>															<input type="text"/>				
Printed Name and Signature of Authorized Group Benefits Administrator															Date (MMDDYY)				
Print										Signature					<input type="text"/>				
<input type="text"/>										<input type="text"/>					<input type="text"/>				

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.

I authorize any healthcare provider, healthcare 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.

**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 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.

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.

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.

