

Subscriber Information																
Last Name			First Name			Middle Initial			Telephone No.				Fax No.			
									(Home)		(Work)		E-mail			
Address (Street No.)				City			State		Zip				<input type="checkbox"/> Male <input type="checkbox"/> Female			
While enrolled in Vytra, will you or any member of your family be covered by: Name of Contract Holder _____ <input type="checkbox"/> Other Health Insurance (Name of insurance) _____ Ins. ID# _____ <input type="checkbox"/> None End Stage Renal Disease <input type="checkbox"/> Yes Social Security Disability Medicare <input type="checkbox"/> Part A. ID # _____ <input type="checkbox"/> Part B ID # _____ <input type="checkbox"/> Individual Coverage <input type="checkbox"/> Family Coverage																
Enrollment Information																
Name <i>Indicate if Last Name is different</i>			Birth Date Mo/Day/Yr		Social Security No.		Sex	Relation -ship	Former Health Coverage <i>(Previous 12 months)</i>		Dates of Former Coverage <i>From To</i>		Primary Care Physician <i>(Choose for each family member)</i> <i>(See Provider Directory)</i>		ID #	Check if current Patient
Your Last Name	First M.I.															
Spouse																
Dependent																
Dependent																
Dependent																
Dependent																
Ob/Gyn Selection <i>(optional for female members)</i>								<input type="checkbox"/> I decline dependent coverage for my spouse. <input type="checkbox"/> I decline dependent coverage for my other dependents.								
Name of Member			Ob/Gyn			ID No.		Have you or any of your dependent(s) ever been a member of Vytra before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Indicate the former employer and your name <i>(if different from shown)</i> _____								
Employer Information <i>Please complete all shaded areas</i>																
Employer Name				Employer Group No.				Date of Hire		Effective Date		Employer Waiting Period				
Address				City			State		Zip	Telephone						
Enrollment											Check one:					
<input type="checkbox"/> I hereby apply for enrollment in Vytra Health Plans Long Island, Inc., which provides health maintenance organization benefits (For HMO use only). <input type="checkbox"/> I hereby apply for enrollment in Vytra Health Plans Long Island, Inc., which provides health maintenance organization benefits. I also apply for coverage under a separate contract from Vytra Health Services, Inc. which provides health insurance. (For POS and MaxAccess use only). The information provided is true and correct to the best of my knowledge. I understand that my coverage and benefits may be affected by failure to provide complete and accurate information. In the event that a premium contribution is required of me, I agree to pay, in advance the premium amounts applicable for the contract under which I am covered. I authorize the employer identified above to deduct from payroll such applicable premium amounts and to remit them to Vytra. I understand that coverage is not included for a pre-existing condition during a 12 month waiting period, or lesser period if eligible for credit for previous coverage. I understand and agree that my employer may discuss my health care coverage with Vytra and provide you with information regarding the coverage and benefits I had with them. I authorize all medical information relative to my care or that of any member of my family to be released to Vytra for all purposes, including but not limited to, compliance with all applicable laws, rules and regulations, quality assurance purposes, HEDIS studies, and those required by HCFA, and for program management purposes. 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 is subject to a civil penalty not to exceed the limits defined in the Insurance Law and the stated value of the claim for each such violation.											<input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire <input type="checkbox"/> Conversion <input type="checkbox"/> Status Change <i>(see below)</i> <i>(Direct Pay)</i>					
											Status <input type="checkbox"/> Add dependent <input type="checkbox"/> Remove dependent Change: <input type="checkbox"/> Address change <input type="checkbox"/> Name change Reason: _____					
											<input type="checkbox"/> Yes <input type="checkbox"/> No Is applicant currently working at least 20 Hrs./Wk.?					
Applicant Signature											Date					
											Employer Signature <i>(Employer must cosign)</i> For Vytra Use Only Please verify employee selection <input type="checkbox"/> HMO Option _____ <input type="checkbox"/> POS Option _____ <input type="checkbox"/> MaxAccess Option _____					

How to Complete the Application

New Members:

- Please complete all applicable information (Enrollment, Subscriber and your signature).
- You **must** select a Primary Care Physician (PCP) for each person covered by the contract. (Please refer to the Provider Directory) Always indicate the Provider ID number.
- Primary Care Physicians include the following specialties: Family Practice, Internal Medicine, and Pediatrics. Female members have the additional option of selecting a participating Vytra Ob/Gyn Provider.
- You may change your PCP by calling Vytra's Customer Service Department. The change will be effective the following day. A new ID card will be sent to you within approximately 10 working days of the change.

Employers:

- Please complete the shaded area, Employer Information. All questions **must** be answered.

For use as a Status Change Form:

- For existing members of Vytra, the form may be used to initiate a change of contract status. For example, single to family coverage, (including name change if applicable) or adding a dependent.
- Check Status Change (the shaded area) and complete form as a new member, with exception of **Effective Date** (the shaded area), which should reflect the date on which the change in contract status takes place. **Note: Additions to the contract (other than newborns) will only be effective on a first of the month basis.** Vytra requires notification within 30 days of event for status changes and may require evidence. (For example: birth certificate, marriage license)



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★ A P P L I C A T I O N

