HIP SmartStart Subscriber/Member Enrollment Form

Last Name	First Name	M.I.	Sex ☐ M ☐ F	Social Security Number
Street Address	Apt.	City	State	Zip Code

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: ___ / ___ / ___

Marital Status
☐ Single
☐ Married ☐ Divorced

Birth Date
Mo. | Day | Yr.

Tel: #: Home: (____) ____________ Work: (____) ____________
E-Mail Address: ______________________

Qualifying Event: ☐ Birth/Adoption ☐ Marriage ☐ Loss of Coverage ☐ New Hire ☐ ____________ **Qualifying Event Date:** Mo.____ Day______ Yr.

Is your spouse 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: ____ / ____ / ____

SUBSCRIBER

Please select a hospital and indicate your choice below

Hospital Name:	Hospital I.D.
Brookhaven Memorial Hospital	BKMH
Good Samaritan Hospital	GSAM
Mercy Medical Center	MERC
New Island Hospital	NEWI
Saint Catherine Hospital	SCAT
St. Charles-JT Mather	SCJM
S Nassau Community	SNAS
Winthrop University Hospital	WINT

Hospital I.D. Selection ____________

Prior Health Insurance Information

Carrier Name ______________________
Coverage Begin Date ___/___/___ Coverage End Date ___/___/___

Have you or any of your dependent(s) ever been a member of HIP? ☐ NO ☐ YES
If yes, indicate member ID number(s) or the former employer and your name
(if different from shown): ______________________

**** If you are enrolling for your spouse and/or children, please list each one below – see Election of Coverage for eligibility***

Last Name (if different)	First Name	Soc. Sec. No.	Sex	Relationship	Birth Date (Mo. / Day / Yr.)	Check if disabled	Spouse Hospital I.D. Selection ____________
SPOUSE		_ _ _ - _ _ - _ _ _ _		☐ Son ☐ Daughter			
Prior Health Insurance Information		Carrier Name ____________ Coverage Begin Date__/__/__ Coverage End Date __/__/__					
ADDITIONAL DEPENDENTS (List oldest first)		_ _ _ - _ _ - _ _ _ _		☐ Son ☐ Daughter			Dependent Hospital I.D. Selection ____________
Prior Health Insurance Information		Carrier Name ____________ Coverage Begin Date__/__/__ Coverage End Date __/__/__					
		_ _ _ - _ _ - _ _ _ _		☐ Son ☐ Daughter			Dependent Hospital I.D. Selection ____________
Prior Health Insurance Information		Carrier Name ____________ Coverage Begin Date__/__/__ Coverage End Date __/__/__					
		_ _ _ - _ _ - _ _ _ _		☐ Son ☐ Daughter			Dependent Hospital I.D. Selection ____________
Prior Health Insurance Information		Carrier Name ____________ Coverage Begin Date__/__/__ Coverage End Date __/__/__					

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**____________

THIS SECTION TO BE COMPLETED BY EMPLOYER/CONTRACTOR GROUP

Name of Group	Group Number	***Type of Coverage:*** ☐ Individual ☐ Family ☐ Employee & Spouse ☐ Employee & Child

Requested Effective Date	Hire Date	Employee Title	Date Submitted to HIP	Approved by *(Representative of Benefits Administrator)*

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

FOR HIP USE ONLY

PROCESSED BY	RECEIVED DATE	PROCESSED DATE

ELECTION OF COVERAGE

I am enrolling for coverage for myself, my spouse and unmarried children under the age limit shown on the group schedule of benefits who are full time students at an accredited educational institution and who are dependent on me and/or my spouse for support.

If I am required to contribute to the premium for my coverage, I hereby authorize my employer to deduct such contributions in advance from wages due me and to remit same to HIP.

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 be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

The following paragraph pertains to small business groups only.

I understand that pre-existing conditions will not be covered during the first 12 months of my enrollment under my group's contract. A pre-existing condition is a condition (whether physical or mental) regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended by a duly licensed medical professional or received within the six (6) month period ending on the enrollment date. Except that, pregnancy is not considered a pre-existing condition and genetic information may not be treated as a pre-existing condition in the absence of a diagnosis of the condition related to such genetic information. HIP will credit the time I/we were covered by the previous policy, provided that the break in coverage under this plan does not exceed sixty-three (63) days, exclusive of any waiting periods. I agree that after enrolled, I will upon request provide HIP and/or my medical group with information on pre-existing conditions and any previous coverage I had. Subject to the applicable State and Federal laws pertaining to pre-existing conditions and creditable coverage, benefits for pre-existing conditions may not be payable for up to twelve months from my effective date under my group's contract.

SECTION A — DOCUMENTATION BASED ON GROUP SIZE

(To be completed by Benefits Administrator)

Group Type (Check One) →

ACTION Check (✔) One	Qualifying Event	Documentation Required	☐ 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** 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	Marriage Certificate			
☐ Add Dependent	Birth	☐ Birth Certificate or			
	Adoption	☐ Formal Adoption Papers or			
		☐ Court Approved Guardianship Papers			
☐ Add Spouse	Loss of Coverage	Certificate of Creditable Coverage			
☐ Add Dependent					

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