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 (DP)

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

Home Tel. #: _____
Work Tel. #: _____
Cell Tel. # (see back of form*): _____

Email Address: _____

Applicant's hours worked per week:
☐ At least 20 hours ☐ Less than 20 hours ☐ COBRA
☐ Retiree (see back of form**)

**Type of Coverage:** ☐ Individual ☐ Family ☐ Employee & Spouse/DP ☐ Employee & Child

**Note:** If electing Young Adult Coverage, please submit a completed Young Adult Election Form.

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

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

**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

**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

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

| Last Name (if different) | First Name | Social Security Number | Sex | Relationship | Birth Date Mo. | Day | Yr. | ✓ if Disabled[1] | Primary Care Physician Name/ID Number (Not required for EPO/PPO members) | OB/GYN Selection Name/ID Number (Optional) |
|---|---|---|---|---|---|---|---|---|---|---|
| DEPENDENT | | | | ☐ Spouse ☐ DP ☐ Child | | | | | | |
| Current Health Insurance Information: | Carrier Name: _____ | | | Coverage Begin Date: _____ | | Coverage End Date: _____ | | | | |
| DEPENDENT | | | | ☐ Child | | | | | | |
| Current Health Insurance Information: | Carrier Name: _____ | | | Coverage Begin Date: _____ | | Coverage End Date: _____ | | | | |
| DEPENDENT | | | | ☐ Child | | | | | | |
| Current Health Insurance Information: | Carrier Name: _____ | | | Coverage Begin Date: _____ | | Coverage End Date: _____ | | | | |

[1]For dependent adult children incapable of self-sustaining employment, please see Section A on the back side of this form to check the appropriate "Add Dependent" box, and follow the instruction for required documentation.

**Your signature is required to process this form. Your signature attests that you have read the reverse side of this form.**
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 material fact associated with such application commits a fraudulent insurance act. Such act is a crime, and will be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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

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

| Name of Group: | Group Number: | Sub Group ID _____ Class ID _____ Plan ID_____ | ☐ HIP ☐ GHI ☐ HIPIC |
|---|---|---|---|
| | If you selected a small group metal plan, please indicate which plan you are selecting:_____ | | Plan Name: _____ |

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

Instructions to Benefit Administrators or Group Representatives: For groups with 100 or fewer full-time equivalent eligible employees, you MUST complete Section A on the reverse side of this form. Required documentation MUST be attached to this Transaction Form to be processed.

## 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 (100 or fewer full-time equivalent eligible employees) provide all necessary documentation.
2. All transactions are subject to EmblemHealth's retroactive enrollment period – members must be enrolled within 30 days (for small groups) or 90 days (for large groups) from the Qualifying Event.
3. As part of New York State's "Age 29" law, eligible young adults through age 29 may 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.
5. Return the completed Transaction Form along with any required documentation to: Membership, PO Box 2820, New York, NY 10116-2820.

Get more information at **www.emblemhealth.com**.

## SECTION A

(To be completed by Benefits Administrator)

| ACTION Check (✔)One | Qualifying Event | Documentation Required |
|---|---|---|
| ☐ Add Subscriber | New Hire or Change in Plan | For eligible employees who work at least 30 hours per week, provide a recent Copy of NYS-45 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 W-4 Form. |
| ☐ Add Spouse | Marriage | **If last name is different**<br>☐ Marriage Certificate<br>☐ 1040 Form |
| ☐ Add Dependent | Birth or Adoption | **If last name is different**<br>☐ Birth Certificate<br>☐ Formal Adoption Papers<br>☐ Court-Approved Guardianship Papers |
| ☐ Add Young Adult | Young Adult Coverage | Young Adult Election Form |
| ☐ Add Dependent | Dependent Adult Child Incapable of Self-Sustaining Employment | Disability Status Request Form |
| ☐ Add Spouse<br>☐ Add Dependent | Loss of Coverage | Certificate of Creditable Coverage |
| ☐ Add Domestic Partner | Domestic Partnership | Declaration of Cohabitation & Financial Interdependence Form |

**Note: No exceptions to our retroactive enrollment period will be allowed. Small group members must be enrolled within 30 days from the Qualifying Event/next billing date (or within 90 days for large group members).**

*I understand that the phone number(s) I provided on this form may be used by EmblemHealth or any of its contracted parties to contact me about my account, my health benefit plan or related programs, or services provided to me.

** Retiree option is applicable for large groups only.



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