

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? <input type="checkbox"/> NO <input type="checkbox"/> YES If YES, member ID _____		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner		Birth Date: Mo. Day Yr.		Telephone #: Home: _____ Work: _____		E-Mail Address: _____ <input type="checkbox"/> "GO PAPERLESS" and save trees (see back of application)*			
Young Adult Coverage: <input type="checkbox"/> 26 And Under — Family <input type="checkbox"/> 26 - 29 — Single Parent ID: _____						Subscriber Employment Status: _____ <input type="checkbox"/> Applicant working at least 20 hours per week					
Disabled? <input type="checkbox"/> NO <input type="checkbox"/> 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? <input type="checkbox"/> NO <input type="checkbox"/> YES If YES, indicate: Insurance Co. Name: _____ Insurance Co. Telephone #: _____ Type of Coverage: _____ Policy #: _____ Effective Date: _____				Check One: <input type="checkbox"/> New Enrollment <input type="checkbox"/> Reinstatement <input type="checkbox"/> Termination <input type="checkbox"/> Change to Ind.		Status: <input type="checkbox"/> Add Dependent <input type="checkbox"/> Remove Dep. <input type="checkbox"/> Address Change <input type="checkbox"/> Name Change		Transfer: <input type="checkbox"/> To Another Carrier <input type="checkbox"/> 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			✓ if Disabled	Primary Care Physician Name/ID Number <small>(Not required for EPO/PPO members)</small>	OB/GYN Selection Name/ID Number <small>(Optional)</small>
					Mo.	Day	Yr.			
DEPENDENT				<input type="checkbox"/> Spouse <input type="checkbox"/> DP <input type="checkbox"/> Child						
Current/Prior Health Insurance Information: Carrier Name: _____ Coverage Begin Date: _____ Coverage End Date: _____										
DEPENDENT				<input type="checkbox"/> Child						
Current/Prior Health Insurance Information: Carrier Name: _____ Coverage Begin Date: _____ Coverage End Date: _____										
DEPENDENT				<input type="checkbox"/> 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:		<input type="checkbox"/> EmblemHealth <input type="checkbox"/> GHI <input type="checkbox"/> GHI HMO <input type="checkbox"/> HIP Plan Name: _____		Type of Coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Employee & Spouse/DP <input type="checkbox"/> Employee & Child			
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 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.

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. 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.

Get more information at www.emblemhealth.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			
		Group Type (Check One)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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
<input type="checkbox"/> 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		
<input type="checkbox"/> Add Spouse	Marriage	If last name is different <input type="checkbox"/> Marriage Certificate <input type="checkbox"/> 1040 Form			
<input type="checkbox"/> Add Dependent	Birth Adoption	If last name is different <input type="checkbox"/> Birth Certificate <input type="checkbox"/> Formal Adoption Papers <input type="checkbox"/> Court Approved Guardianship Papers			
<input type="checkbox"/> Add Spouse <input type="checkbox"/> Add Dependent	Loss of Coverage	Certificate of Creditable Coverage			
<input type="checkbox"/> 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.