Small Group Employee Enrollment Application

The employee who completes this application is solely responsible for its accuracy and completeness. Be sure to answer all questions and to sign and date your application. Please complete in black ink only.

Section A: Employer and Employee Information				
Employer name				
Employment status ☐ Full-time ☐ Part-time ☐ Retired	Date of hire (MM/DD/YYYY) / /	Date waiting period begins (MM/DD/YYYY) / /		
Employee home address - Street and PO Box if applicable	City	County	State	ZIP code
Primary phone no.	Employee email address			

By providing my email address I agree to get information about my benefits by email, including my Evidence of Coverage, explanation of benefits and other information. These emails may include specific details about me and my plan. I know I can change my mind at any time and request a free copy of specific materials by mail by going to www.empireblue.com or calling Member Services.

Application type – select one: ☐ New enrollment ☐ Open enrollment ☐ COBRA ☐ Rehire date: (MM/DD/YYYY) _____/_____/_____

Language choice (optional): ☐ English ☐ Spanish ☐ Chinese ☐ Korean ☐ Other – please specify: _____

Select qualifying event for special enrollment by employee, spouse or dependent child.

☐ Mandatory Right of Election to continue Dependent coverage through age 29 (qualified dependents only)

Loss of coverage in other group plan due to:

☐ Loss of dependent child status ☐ Reduction in hours ☐ Gain or become a dependent via marriage, birth or adoption
☐ Death of spouse ☐ COBRA/ State continuation is exhausted ☐ Loss of or become eligible for Medicaid or Child Health Plus
☐ Employer ends plan contributions ☐ Employment termination
☐ Other group plan ends ☐ Legal separation, divorce or annulment

Select qualifying event for COBRA:

☐ Death of subscriber ☐ Employee becomes eligible for Medicare ☐ Divorce or legal separation from subscriber
☐ Employment termination ☐ Reduction in hours ☐ Loss of dependent child status

Section B: Employee and Dependent Type of Coverage and Coverage Information – Complete this section for you and dependents to be covered. All fields required. Attach a separate sheet if necessary.

Enrollee	**Employee/Subscriber**	**Spouse/Domestic Partner**	**Dependent***	**Dependent***
Social Security no.[1]	- -	- -	- -	- -
Birthdate (MM/DD/YYYY)	/ /	/ /	/ /	/ /
Last name				
First name, Middle initial				
Sex	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Check all that apply:		☐ Domestic Partner	☐ Young adult[2]	☐ Young adult[2]
*Enter dependent's address, if different:				

If your overage adult dependent is impaired, complete the NY Handicapped/Dependent Form (HAC 506), which can be found at https://www.empireblue.com/employer/forms/.

1 Empire BlueCross BlueShield (Empire) is required by the Internal Revenue Service to collect this information.
2 Your dependent between ages 26-30 may be covered if your employer has chosen this option or if you or your eligible dependent buy extended coverage through age 29.

Medical Coverage				
Enrollee	**Employee/Subscriber**	**Spouse/Domestic Partner**	**Dependent**	**Dependent**
Medical contract code				
Enrollment status	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive
Primary Care Physician (PCP) name[3]				
PCP ID no.				
Existing patient	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dental Coverage				
Dental contract code				
Enrollment status	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive
Primary Care Dentist (PCD) name[3]				
PCD ID no.				
Existing patient	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Vision Coverage				
Vision contract code				
Enrollment status	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive

Section C: Prior and Other Group Coverage

Is anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ No If yes, give name: ______________________________

Medicare ID no.	Part A effective date (MM/DD/YYYY) / /	Part B effective date (MM/DD/YYYY) / /	Medicare eligibility reason(select all that apply) ☐ Age ☐ Disability ☐ ESRD: Onset date (MM/DD/YYYY) _____/_____/_____

Medicare Part D ID no.	Medicare Part D Carrier	Part D effective date (MM/DD/YYYY) / /

Is anyone applying for coverage covered by other health insurance? ☐ Yes ☐ No If yes, please provide the following:

Name of person covered (Last, First, M.I.)	Type (select one)	Coverage (select all that apply)	Insurer name	Insurer phone no.	Policy ID no.	Dates (if applicable) (MM/DD/YYYY)
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				Start: ____/_____/______ End: ____/_____/______
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				Start: ____/_____/______ End: ____/_____/______
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				Start: ____/_____/______ End: ____/_____/______
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				Start: ____/_____/______ End: ____/_____/______

3 To select a PCP and/or PCD, visit our website at www.empireblue.com/find-doctor. If your Empire benefit plan requires you to pick a PCP and/or PCD and you do not select one, we will assign one to you. You will be able to change to another PCP and/or PCD by contacting us.

Section D: Terms, Conditions and Authorizations – Please read this section carefully before signing the application.

In signing this application I represent that: I have read or have had read to me the completed application, and I realize any false statement or misrepresentation may result in loss of coverage. I certify each Social Security Number listed on this application is correct.

As an eligible employee, I request coverage for myself and eligible dependents listed and authorize my employer to deduct any required contributions for this insurance from my earnings. I understand all benefits are subject to conditions stated in my employer's Group Contract and my Evidence of Coverage.

Special Enrollment Rights – Medical Coverage Only. If you declined enrollment for yourself or your dependent(s) (including a spouse) because of other group health plan coverage, you can enroll yourself and your dependent(s) in this plan if you or your dependent(s) lose eligibility for the other group health plan due to any of the following: termination of employment; termination of the other group health plan; death of your Spouse; legal separation, divorce or annulment; reduction of hours of employment; employer contributions toward the group health plan were terminated; or a child no longer qualifies for coverage as a child under the other group health plan. You must request enrollment within 31 days after the other coverage ends (or after the employer contributions ends).

You may also enroll 31 days from the date your exhaust COBRA or state continuation coverage. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll yourself and your dependent(s) starting on the date of birth if you request enrollment within 60 days after the birth, adoption or placement for adoption. Otherwise, coverage begins on the date we receive notice of the birth or adoption, provided you pay additional premium when due.

If you get married while covered, you can add your Spouse effective on the date of your marriage if you tell us within 31 days. You, your Spouse or child can also enroll within 60 days of the occurrence of the following circumstances: You or Your Spouse or Child loses eligibility for Medicaid or Child Health Plus; or You or Your Spouse or Child becomes eligible for Medicaid or Child Health Plus.

Health Savings Account: If you want to establish a Health Savings Account (HSA) with an HSA-compatible health plan, a bank needs to act as the HSA financial custodian. By signing below you hereby authorize the financial custodian to provide Empire with information about your HSA, including account no., account balance and information about account activity. You may revoke this authorization at any time in writing.

INSURANCE FRAUD STATEMENT: 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 also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Sign here	Applicant signature X	Today's date (MM/DD/YYYY) / /
Sign here	Company officer signature X	Today's date (MM/DD/YYYY) / /
	Printed name	Group no.

Get help in your language

Language Assistance Services

Empire BlueCross BlueShield
An Anthem Company

Curious to know what all this says? We would be too. Here's the English version:
If you need assistance to understand this document in an alternate language, you may request it at no additional cost by calling the Member Services number (855-748-1806). (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the Member Services telephone number on the back of your ID card.

Spanish
Si necesita ayuda para entender este documento en otro idioma, puede solicitarla sin costo adicional llamando al número de Servicios para Miembros (855-748-1806). (TTY/TDD: 711)

Albanian
Nëse ju nevojitet ndihmë për ta kuptuar këtë dokument në një gjuhë tjetër, mund ta kërkoni pa kosto shtesë duke telefonuar në numrin e shërbimeve për anëtarët (855-748-1806). (TTY/TDD: 711)

Arabic
إذا احتجت إلى المساعدة لفهم هذا المستند بلغة أخرى، فيمكنك طلب المساعدة دون تكلفة إضافية من خلال الاتصال برقم خدمات الأعضاء (855-748-1806). (TDD/TTY: 711)

Bengali
একটি বিকল্প ভাষায় এই তথ্য পুস্তিকাটি বোঝার জন্য। যদি আপনার সহায়তার প্রয়োজন হয়, তাহলে কোনো অতিরিক্ত খরচ ছাড়া সদস্য পরিষেবা নম্বর (855-748-1806)-তে কল করে আপনি এটির অনুরোধ করতে পারেন। (TTY/TDD: 711)

Chinese
如果您需要協助以便以另一種語言理解本文件，您可以撥打成員服務號碼(855-748-1806)請求免費協助。(TTY/TDD: 711)

French
Si vous avez besoin d'aide pour comprendre ce document dans une autre langue, vous pouvez en faire la demande gratuitement en appelant les Services destinés aux membres au numéro suivant : 855-748-1806. (TTY/TDD: 711)

Greek
Αν χρειαστείτε βοήθεια για να κατανοήσετε το παρόν έγγραφο σε άλλη γλώσσα, μπορείτε να τη ζητήσετε χωρίς πρόσθετο κόστος καλώντας τον αριθμό του Τμήματος Υπηρεσιών Μέλους (855-748-1806). (TTY/TDD: 711)

Haitian
Si ou bezwen èd pou konprann dokiman sa a nan yon lòt lang, ou kapab rele nimewo Manm Sèvis la pou mande asistans gratis nan nimewo (855-748-1806). (TTY/TDD: 711)

Italian
Se ha bisogno di assistenza per la comprensione del presente documento in un'altra lingua, può richiederla senza alcun costo aggiuntivo chiamando il numero dedicato ai Servizi per i membri (855-748-1806). (TTY/TDD: 711)

Korean
다른 언어로 본 문서를 이해하기 위해 도움이 필요하실 경우, 추가 비용 없이 회원 서비스 번호(855-748-1806)로 전화를 걸어 도움을 요청할 수 있습니다. (TTY/TDD: 711)

Polish
Jeśli potrzebujesz pomocy w zrozumieniu niniejszego dokumentu w innym języku, możesz ją uzyskać bez ponoszenia dodatkowych kosztów, dzwoniąc do Działu Obsługi Klienta pod numer (855-748-1806). (TTY/TDD: 711)

Russian
Если вам нужна помощь, чтобы понять содержание настоящего документа на другом языке, вы можете бесплатно запросить ее, позвонив в отдел обслуживания участников (855-748-1806). (TTY/TDD: 711)

Tagalog
Kung kailangan ninyo ng tulong upang maunawaan ang dokumentong ito sa ibang wika, maaari ninyo itong hilingin nang walang karagdagang bayad sa pamamagitan ng pagtawag sa Member Services sa numerong (855-748-1806). (TTY/TDD: 711)

Urdu
تو آپ ممبر سروس نمبر پر کال اگر آپ کو کسی دوسری زبان میں اس دستاویز کو سمجھنے کے لیے مدد کی ضرورت ہو
جس کے لئے آپ پر کوئی اضافی اخراجات عائد نہیں ہوں گے نمبر کرکے اس کی درخواست کرسکتے ہیں
(711:TDD/TTY) (855-748-1806)

Yiddish
אויב איר דארפט הילף צו פארשטיין דעם דאקומענט אין אן אנדערע שפראך, קענט איר עס בעטן אהן קיין
עקסטערע קאסט דורך רופן די מעמבער באדינונגען נומער
(711:TDD/TTY) (855-748-1806)

It's important we treat you fairly
That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.