healthfirst
Health Insurance for New Yorkers

Healthfirst Insurance Company, Inc.

Small Group Employee Enrollment Application

Mailing Address:
Healthfirst Insurance Company, Inc., P.O. Box 1566, New York, NY 10008-1516

Broker Services: 1-855-456-3668
Employer Services: 1-855-949-3668

Please print neatly using black or blue ink, complete the enrollment form **in full**, and **sign** the last page. Incomplete or unsigned forms will not be processed.

Section 1 | Group Information (to be completed by Plan Administrator)

Company Name	Billing Group (If Applicable)	Group Number
Effective Date _____/_____/_____	Title	Date of Hire or Rehire _____/_____/_____ Include the most recent date
Employer Signature	Date _____/_____/_____	

Section 2 | Transaction Type (check all that apply)

☐ Open Enrollment ☐ New Hire ☐ Rehire ☐ Young Adult*

☐ COBRA/State Continuation
Date of Termination/Loss of Coverage: _____/_____/_____ Reason for COBRA Eligibility: _____

*Check this box only if your employer's coverage does not cover dependents up to age 29 and you would like to purchase a separate policy for the age 29 dependent.

Section 3 | Health Savings Account (HSA)

Do you want to open a health savings account (HSA) that is offered with the Bronze Plan? ☐ Yes ☐ No

By selecting Yes, you: (i) confirm that you are an HSA eligible individual (see IRS Publication 969 https://www.irs.gov/pubirs-pdf/p969.pdf) and desire to open an HSA with HealthEquity (https://www.healthequity.com/), (ii) authorize and instruct Healthfirst to provide information to HealthEquity on your behalf in order to open an HSA, (iii) acknowledge that, as part of your application for an HSA, and in accordance with the USA PATRIOT Act, HealthEquity must verify your identity, which may require that you provide additional information and/or documentation (such as a driver's license or other identifying information before your HSA can be opened, and (iv) authorize and instruct HealthEquity to share account information with Healthfirst related to the opening and maintenance of the HSA.

HealthEquity is the administrator for your Health Savings Account (HSA). HealthEquity is an Internal Revenue Service (IRS) authorized, non-bank trustee operating as the custodian of health savings accounts (HSAs) as described in section 223 of the Internal Revenue Code.

Section 4 | Coverage Selection

Please choose from the plan(s) that your employer is offering and write the name of the plan below. Contact your employer or plan administrator if you have any questions.

Plan Name: _____

Section 5 | Employee Information

First Name	Middle Initial	Last Name		
Mailing Address		City	State	Zip Code

Section 6 | Employee/Dependent(s) Information

	Employee/Subscriber	Spouse	Dependent 1	Dependent 2
Social Security Number (or Tax Identification Number, if applicable)	____-____-____	____-____-____	____-____-____	____-____-____
Last Name*				
First Name, Middle Initial*				
Phone Number				
Email Address				
Date of Birth (MM/DD/YYYY)*	/ /	/ /	/ /	/ /
Gender*	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Primary Care Provider** (PCP) Name				
PCP ID Number				
Currently covered under another insurance?†	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If Yes, select type:	☐ Medical ☐ Dental	☐ Medical ☐ Dental	☐ Medical ☐ Dental	☐ Medical ☐ Dental
Company Name				
Coverage Beginning/End Dates	___/___/___ – ___/___/___	___/___/___ – ___/___/___	___/___/___ – ___/___/___	___/___/___ – ___/___/___
Policy Number				

*Mandatory.

**If you do not select a PCP, one will be auto-assigned to you.

†Indicate if you will have other coverage under another plan after enrolling with Healthfirst.

Section 6 | Employee/Dependent(s) Information (continued)

	Dependent 3	Dependent 4	Dependent 5	Dependent 6
Social Security Number (or Tax Identification Number, if applicable)	___-___-___	___-___-___	___-___-___	___-___-___
Last Name*				
First Name, Middle Initial*				
Phone Number				
Email Address				
Date of Birth (MM/DD/YYYY)*	/ /	/ /	/ /	/ /
Gender*	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Primary Care Provider** (PCP) Name				
PCP ID Number				
Currently covered under another insurance?†	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If Yes, select type:	☐ Medical ☐ Dental	☐ Medical ☐ Dental	☐ Medical ☐ Dental	☐ Medical ☐ Dental
Company Name				
Coverage Beginning/End Dates	___/___/___ – ___/___/___	___/___/___ – ___/___/___	___/___/___ – ___/___/___	___/___/___ – ___/___/___
Policy Number				

*Mandatory.

**If you do not select a PCP, one will be auto-assigned to you.

†Indicate if you will have other coverage under another plan after enrolling with Healthfirst.

Section 7 | Conditions of Enrollment

On behalf of myself and the dependent(s) listed in Section 6, I agree to or with the following:

- I understand that my employer's application will determine coverage and that there is no coverage unless and until both the eligible-employee enrollment form and the employer application have been accepted and approved by Healthfirst.
- I understand and agree that this enrollment form may be transmitted to Healthfirst or its agent by my employer or its agent.
- The plan certificate of coverage will determine the rights and responsibilities of member(s). It will govern in the event they conflict with any benefits comparison, summary, or other description of the plan.

Section 8 | Misrepresentation

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.

Employee Signature: _____ **Date:** _____/_____/_____

Section 9 | Acknowledgment and Signature

I consent to the release of any health information about me and my dependents for whom I can give consent, by our healthcare providers to Healthfirst and by Healthfirst to our healthcare providers, as reasonably necessary for Healthfirst or our providers to carry out treatment, payment, or healthcare operations. I agree that the information released for treatment, payment, and healthcare operations may include confidential HIV, mental health, and alcohol and substance abuse information about me and my dependents to the extent permitted by law. This consent will expire one year after the end of my enrollment with Healthfirst.

I represent that to the best of my knowledge and belief all information supplied in this form is true and complete. I have read, and I agree to, information listed on this Healthfirst Insurance Company, Inc. Small Group Employee Enrollment Form. I understand that if I do not sign this form within 30 days from the date first eligible or within 30 days of the qualifying life event (i.e., marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.), I will be considered a late enrollee, which may affect the effective date of coverage for me and my dependents. I am employed by the employer shown in Section 1, and I am working full time at least 20 hours per week for this employer at the regular place of business. I authorize Healthfirst to electronically transmit the information contained in this application. In addition, I consent to electronic communication with Healthfirst. I may withdraw my consent for electronic communication by contacting Member Services at the number on my ID card and requesting that future communication be sent in written form.

Employee Signature: _____ **Date:** _____/_____/_____

Employee Email Address: _____

healthfirst®
Health Insurance for New Yorkers

Notice of Non-Discrimination

Healthfirst complies with Federal civil rights laws. **Healthfirst** does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Healthfirst provides the following:

- Free aids and services to people with disabilities to help you communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose first language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call **Healthfirst** at **1-866-305-0408**. For TTY services, call 1-888-542-3821.

If you believe that **Healthfirst** has not given you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with **Healthfirst** by:

- **Mail:** Healthfirst Member Services, P.O. Box 5165, New York, NY, 10274-5165
- **Phone: 1-866-305-0408** (for TTY services, call 1-888-542-3821)
- **Fax:** 1-212-801-3250
- **In person:** 100 Church Street, New York, NY 10007
- **Email: http://healthfirst.org/members/contact/**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by:

- **Web:** Office for Civil Rights Complaint Portal at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**
- **Mail:** U.S. Department of Health and Human Services
  200 Independence Avenue SW., Room 509F, HHH Building
  Washington, DC 20201
  Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**
- **Phone: 1-800-368-1019** (TTY 800-537-7697)

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-866-305-0408 (TTY 1-888-542-3821).	English
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-305-0408 (TTY: 1-888-867-4132).	Spanish
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-305-0408 (TTY: 1-888-542-3821).	Chinese
ملحوظة: إذا كنت تتحدث العربية، فسوف تتوفر خدمات المساعدة اللغوية لك بالمجان. اتصل برقم 1-866-305-0408 (TTY: 1-888-542-3821).	Arabic
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다 1-866-305-0408 (TTY: 1-888-542-3821).번으로 전화해 주십시오.	Korean
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-305-0408 (TTY: 1-888-542-3821).	Russian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-305-0408 (TTY: 1-888-542-3821).	Italian
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-305-0408 (TTY: 1-888-542-3821).	French
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-305-0408 (TTY: 1-888-542-3821).	French Creole
אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון 1-866-305-0408 (TTY: 1-888-542-3821). אפצאל. רופט	Yiddish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-305-0408 (TTY: 1-888-542-3821).	Polish
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-305-0408 (TTY: 1-888-542-3821).	Tagalog
লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১1-866-305-0408 (TTY: 1-888-542-3821).	Bengali
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-866-305-0408 (TTY: 1-888-542-3821).	Albanian
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-866-305-0408 (TTY: 1-888-542-3821).	Greek
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-866-305-0408 (TTY: 1-888-542-3821).	Urdu