healthfirst
Health Insurance for New Yorkers

Healthfirst Insurance Company, Inc.

New York Individual Enrollment Application

Mailing Address:
Healthfirst Insurance Company, Inc., P.O. Box 1566, NY, NY 10277-2138
Member Services: **1-855-789-3668**

Application Instructions:
Please supply all the information requested on this form. We want to process your application quickly, but if this form is incomplete we will have to return it. Be sure to include:

1. Two proofs of applicant's (or responsible adult's) address
Name and address on proof must be exactly the same as name and address in Section 1.
Acceptable proofs of address include photocopies of:

- Valid New York State driver's license
- Voter Registration Card
- Current income tax return, current lease, or current utility bill (excluding a cellular phone bill)

If mailing address is different than street address, please provide mailing address under separate cover.

2. Include the first month's premium, payable to Healthfirst Insurance Company, Inc.

Section 1 | Applicant/Responsible Party

Name			
Primary Business Address	City	State	Zip Code
Phone Number	Email Address		

1. Are you or any dependents either eligible for, or currently on, Medicare for any reason? ☐ Yes ☐ No

If "Yes," please enter name: _____

2. If 20 years or younger, do you want to opt for the child-only plan? ☐ Yes ☐ No

If "Yes," which coverage tier would you want? ☐ Single ☐ 2 Children ☐ 3+ Children

3. Which coverage tier do you want (leave blank if opting for child-only plan)?
☐ Single ☐ Couple ☐ Parent/Child(ren) ☐ Family

4. Additional benefit options:
Dependent coverage extension through age 29? ☐ Yes ☐ No

Note: Eligibility for children covered under the subscriber's contract may be extended through age 29 if the young adult is unmarried; is not insured by or eligible for coverage under an employer-sponsored health benefit plan covering him or her as an employee or member, whether insured or self-insured; and lives, works, or resides in New York State or in Healthfirst Insurance Company, Inc.'s service area.

5. When would you like your coverage to begin? (MM/DD/YYYY) _____/_____/_____

Note: For coverage to be effective on the desired date, all application materials and the first month's premium must be submitted by the 15th of the month prior to the desired date. If the above materials are submitted after the 15th of the month of the desired effective date, Healthfirst Insurance Company, Inc. reserves the right to effectuate coverage for the subsequent month.

6. Are you applying for coverage as a result of a Qualifying Life Event? ☐ Yes ☐ No

If "Yes," please provide information below
Reason: _____
Date of Event: _____

Section 2 | Coverage Selection

☐ Platinum Total EPO ☐ Gold Total EPO ☐ Silver Total EPO ☐ Bronze Total EPO

Section 3 | Member/Dependent(s) Information

	Applicant	Spouse/Domestic Partner	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 (if available)				
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				

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

Section 3 | Member/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 (if available)				
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				

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

Section 4 | 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.

Applicant's Signature: _____ **Date:** _____/_____/_____

Section 5 | 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, the information on this enrollment application form. I understand that if I do not sign this form within 60 days from the date first eligible or within 60 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 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.

If I am applying for coverage outside of Healthfirst Insurance Company Inc.'s "Annual Open Enrollment Period," I must include proof of my Qualifying Life Event to be eligible to enroll.

Applicant's Signature: _____ **Date:** _____/_____/_____

Applicant's 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