



Administrative Offices • (716) 847-0881 • Fax (716) 504-5573
 205 Park Club Lane • Buffalo, NY 14221-3998

**THANK YOU FOR JOINING
 UPON COMPLETION RETURN TO YOUR EMPLOYER
 HEALTHY NEW YORK SMALL GROUP
 ATTN: SALES DEPT. (GROUP APPS.)
 UNIVERA HEALTHCARE
 205 PARK CLUB LANE
 BUFFALO, N. Y. 14221**

A. SUBSCRIBER INFORMATION

HAVE YOU EVER BEEN A PATIENT OR MEMBER OF UNIVERA HEALTHCARE?
 NO YES (NAME AT THE TIME)

LAST NAME: _____ FIRST NAME: _____ INITIAL: _____ BIRTHDATE: _____ GENDER: _____

SOCIAL SECURITY #: _____ DATE OF HIRE: _____ MARITAL STATUS (CHECK ONE):
 MARRIED SINGLE DIVORCED WIDOWED LEGALLY SEPARATED

STREET ADDRESS: _____ APT #: _____ CITY: _____ STATE: _____ ZIP: _____ COUNTY: _____

HOME PHONE: _____ WORK PHONE: _____ EXTENSION: _____

B. OTHER HEALTH INSURANCE INFORMATION

WHILE ENROLLED IN UNIVERA HEALTHCARE WILL YOU OR ANY MEMBER OF YOUR FAMILY BE COVERED BY OTHER GROUP HEALTH INSURANCE?: YES NO
 OTHER PLAN COVERS: SELF SPOUSE CHILD(REN) ENTIRE FAMILY

NAME OF THE PERSON WITH OTHER INSURANCE: RELATIONSHIP TO UNIVERA SUBSCRIBER:
 SELF SPOUSE

NAME OF OTHER INSURANCE: _____

POLICY # WITH OTHER INSURANCE: _____ EFFECTIVE DATE: _____

ADDRESS WHERE YOU SEND YOUR CLAIMS: _____

WHILE ENROLLED IN UNIVERA HEALTHCARE WILL YOU OR ANY MEMBER OF YOUR FAMILY BE COVERED BY: MEDICARE: YES NO
 SELF SPOUSE CHILD(REN) ENTIRE FAMILY

NAME OF THE PERSON WITH MEDICARE: RELATIONSHIP TO UNIVERA SUBSCRIBER:
 SELF SPOUSE

MEDICARE #: _____ PART A EFFECTIVE DATE: _____ PART B EFFECTIVE DATE: _____

BASIS OF ENTITLEMENT: DISABILITY RETIRED END STAGE RENAL DISEASE

C. PHYSICIAN SELECTION AND DEPENDENT INFORMATION

YOU MUST CHOOSE PCP TO RECEIVE FULL BENEFITS

	LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY	SEX	BIRTH DATE	RELATION	PRIMARY MD NAME	CURRENT PATIENT	OB/GYN NAME
SELF							SELF		<input type="checkbox"/> YES <input type="checkbox"/> NO	
SPOUSE							SPOUSE		<input type="checkbox"/> YES <input type="checkbox"/> NO	
CHILD							<input type="checkbox"/> NATURAL CHILD <input type="checkbox"/> *OTHER		<input type="checkbox"/> YES <input type="checkbox"/> NO	
CHILD							<input type="checkbox"/> NATURAL CHILD <input type="checkbox"/> *OTHER		<input type="checkbox"/> YES <input type="checkbox"/> NO	
CHILD							<input type="checkbox"/> NATURAL CHILD <input type="checkbox"/> *OTHER		<input type="checkbox"/> YES <input type="checkbox"/> NO	

D. EMPLOYER INFORMATION

EMPLOYER NAME _____ GROUP NO. (TO BE COMPLETED BY EMPLOYER) _____ SUB GROUP NO. (TO BE COMPLETED BY EMPLOYER) _____ COVERAGE EFFECTIVE DATE _____

CHECK ONE: OPEN ENROLLMENT NEW HIRE COBRA ELECTION ADD DEPENDENT REMOVE DEPENDENT PCP CHANGE ADDRESS CHANGE NAME CHANGE MARRIAGE DIVORCE

E. NARRATIVE

I hereby apply for membership in Univera Healthcare for myself and the eligible dependents listed above. This information provided is true and correct to the best of my knowledge. I understand that my coverage and benefits may be affected by my failure to provide complete and accurate information. I also hereby apply for coverage under the Univera Access contract, a health insurance program.

In the event that a premium contribution is required of me, I agree to pay, in advance, the premium amounts applicable for the contract under which I am covered. I authorize the employer identified above to deduct from payroll such applicable amounts and to remit them to Univera Healthcare. I consent to the receipt and/or release of medical records and other information necessary to Univera Healthcare or its Providers for the purposes of providing necessary health care services and/or administrative services. I also consent to the assignment of benefits to Univera Healthcare which I may have in circumstances where a party other than Univera Healthcare may be responsible for all, or a portion of, the cost of services provided to me. These consents shall remain in force and effect for the duration of my membership in Univera Healthcare.

Note: 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 \$5,000 and the stated value of the claim for such violation. I have thoroughly read, understand and agree to comply with the terms of the above release.

ALL SECTIONS MUST BE COMPLETED BEFORE PROCESSING

SIGNATURE _____ DATE _____ GROUP ADMINISTRATOR _____ DATE _____