FOR INTERNAL USE ONLY	
HIOS ID#:	78124NY1120009-00
EC:	SHD5

Group Health Insurance Application/Change Form

- Please print clearly and complete all sections that apply to you
- Additional instructions are included
- This application cannot be processed without this information and a signature

Section 1: Employer Group Information

This section should be completed by the Group Benefits Administrator

Medical Group Number (8 digits) ____________ Medical Subgroup Number (4 digits) ____________ Medical Class Number (4 digits) ____________

Dental Group Number ____________ Dental Subgroup Number ____________

Employer Name ____________ Association/Chamber Name (if applicable) ____________

Group Administrators Signature ____________ Date ____________

Subscriber Status:

Date of Hire: ___ /___ /____

☐Rehire- Date of Rehire: ___ /___ /____

☐Retired - Effective Date: ___ /___ /____

☐COBRA - Effective Date: ___ /___ /____

☐Cancelled -- Effective Date: ___ /___ /____

Please indicate reason for COBRA if applicable:

☐Left Employment/Retired ☐Divorce/Legal Separation ☐Loss of Student Status ☐Death of Subscriber

☐Dependent Reached Max Age ☐ Other: ____________

Section 2: Your Information

This section should be completed by the Subscriber

Last Name ____________ First Name ____________ MI ____ Social Security #** ____________

Birthdate ___ /___ /____ Sex: Male ☐ Female ☐

Street Address ____________ City ____________ State ____ Zip ____

Phone ____________

Email ____________ Would you like to receive emails about health & wellness? ☐ Yes No☐

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal

Medicare Number (if applicable) ____________ Part A Effective Date: ___/___/____ Part B Effective Date: ___/___/____

Marital Status: ☐Single ☐Married ☐Legally Separated ☐Divorced/Marital Status Event Date ___/___/______

Section 3: Subscriber Medical Plan Selection

Healthy New York EPO

If enrolling in a Medical plan, who do you need coverage for?

☐Self Only ☐Self & Child (ren)

☐Self & Spouse/Domestic Partner ☐Family

Effective Date: ___/___/______

Section 4: Subscriber Dental Plan Selection

Please select plan if applicable:

☐Univera Dental Traditions (DI) ☐Univera Dental Select (DJ)

If enrolling in a Dental plan, who do you need coverage for?

☐Self Only ☐Self & Child (ren)

☐Self & Spouse/Domestic Partner ☐Family

Medical & Dental Effective Date: ___/___/___

Pediatric dental is an essential health benefit mandated by the ACA. If your employer group does not provide pediatric dental coverage through this Univera Healthcare plan, you agree to enroll in the dental plan offered to you by your employer.

Section 5: Please indicate the reason for this enrollment or change

☐New Hire / Rehire ☐Open Enrollment ☐Retirement ☐Loss of Coverage ☐COBRA

☐Medicare Eligible ☐Change in employment status ☐Change to new employer that does not offer insurance

☐Loss of eligibility through employer or discontinuation of employer coverage

☐Marital Status Change ☐Marriage ☐Divorce ☐Dependent reaches maximum age of coverage

☐Address Change ☐Last Name Change ☐A move in or out of service area

☐Remove Dependent ☐Death

☐Add Dependent: Please indicate reason ☐Newborn ☐Marriage ☐Other ________________

Date of Event ___/___/________

Section 6: If canceling coverage, who are you canceling coverage for?

☐Subscriber

☐Medical Cancellation Date ___/___/_____ ☐Dental Cancellation Date ___/___/_____

☐Dependent(s) (List each dependent below in section 8)

☐Medical Cancellation Date ___/___/_____ ☐Dental Cancellation Date ___/___/_____

Why are you canceling coverage?

☐Subscriber's request ☐Divorce ☐Deceased ☐Medicare/Medicaid or other coverage

☐Coverage through spouse ☐Loss of eligibility through employer or discontinuation of employer coverage

☐Other ________________

Section 7: Information about who you would like coverage for

☐Spouse ☐Domestic Partner ☐Dependent Child ☐Disabled Dependent Child *Separate form required

☐Other______________

Sex: Male ☐ Female ☐ Birthdate ___/___/_______

Last Name (if different) ______ First Name ______ MI ______ Social Security #** ______

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal

Part A Effective Date: ___/___/____ Part B Effective Date: ___/___/____

Medicare Number (if applicable) ______

☐Dependent Child ☐Disabled Dependent Child*Separate form required ☐Other__________________

Sex: Male ☐ Female ☐ Birthdate ___/___/_______

Last Name (if different) ______ First Name ______ MI ______ Social Security #** ______

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal

Part A Effective Date: ___/___/____ Part B Effective Date: ___/___/____

Medicare Number (if applicable) ______

☐Dependent Child ☐Disabled Dependent Child*Separate form required ☐Other___________________

Sex: Male ☐ Female ☐ Birthdate ___/___/______

Last Name (if different) First Name MI Social Security #**

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal

Part A Effective Date: ___/___/____ Part B Effective Date: ___/___/____

Medicare Number (if applicable)

☐Dependent Child ☐Disabled Dependent Child*Separate form required ☐Other___________________

Sex: M ☐ F ☐ Birthdate ___/___/______

Last Name (if different) First Name MI Social Security #**

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal

Part A Effective Date: ___/___/____ Part B Effective Date: ___/___/____

Medicare Number (if applicable)

Note: Use an additional application if more than four people need coverage.

Section 8: Other coverage information (Must be completed – you may be contacted for additional information)

Are you or any member of your family enrolled in other coverage? ☐Yes ☐No

If yes, are you keeping the coverage? ☐Yes ☐No

If no, when will the coverage cancel? __/__/__

Policyholder's name ______________________________ ID# ________________________

Effective Date: ___/___/____

Who did the insurance cover? ☐Self Only ☐Self & Child(ren) ☐Self & Spouse/Domestic Partner ☐Family

Section 9: Release – You must sign and date this form to be eligible for health insurance.

I acknowledge and agree that by signing this enrollment form and subsequently accepting services, I and everyone else who is covered under the contract you issue is bound by the terms and conditions of the contract applicable to my coverage. This includes, without limitation, the terms and conditions regarding the receipt and release of medical records and information. I make this acknowledgement and agreement on behalf of myself and each other person who accepts coverage under the terms of the contract applicable to my coverage (who may include, for example my spouse and my eligible family dependents).

I hereby accept responsibility for payment of any portion of the premium.
I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

EXCLUSIVE PROVIDER ORGANIZATION (EPO)
I understand that if I elect Exclusive Provider Organization (EPO) coverage, except in an emergency, all care must be provided by medical providers who participate with the EPO and I will not receive benefits for care that I receive from providers who do not participate with the EPO.

PREFERRED PROVIDER ORGANIZATION (PPD)
I understand that the Preferred Provider Organization (PPO) coverage is comprised of an in-network benefit that is dependent on the utilization of medical providers who participate with the PPO and out-of-network benefit that provides coverage for services of medical providers who do not participate with the PPO. I understand that the in-network benefit provides the highest level of coverage under the plan.

I have thoroughly read, understand and agree to comply with the terms of the release in this section.
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 each such violation.

Subscriber Signature____ **Date**________________

Please return to PO Box 22999, Rochester, NY 14692. If you have questions, please contact your Group Administrator.
Or, visit us at: UniveraHealthcare.com