



PO Box 15013, Albany, NY 12212-5013

Enrollment Application/Change Form — SMALL

Subscriber Status: Active Retired COBRA	
	Please indicate reason for COBRA:
Group # Subgroup # Class #	○ Left Employ / Retirement ○ Death of Spouse
	Divorce/Legal Separation Dependent Reached Max Age
Employer Name	Loss of Student Status Other
	Effective Date (MMDDYY) COBRA Effective Date (MMDDYY)
Association/Chamber Name (if applicable)	
	Hire/Rehire Date (MMDDYY) Retired Effective Date (MMDDYY)
Group Administrator Signature / Date	
√	
Subscriber Plan Section Please use blue or black ink, print one ch	naracter per box. Check applicable plan(s).
Plan Number: PCP \$	Specialist \$ Single or Family:
O POS O POS Plus O Dental O HMO O HMO Plus	Please choose coverage type
PPO Traditional Vision EPO Aqua	Other Obental S F
	○ Vision ○ S ○ F
A. Have you obtained stand-alone dental coverage that provides a pediatric dental esses New York Health Benefit Exchange-certified stand-alone dental plan offered outside:	
B. If you answered "yes", please provide the name of the company issuing the stand-alo	0 -
If you answered "no", we will provide coverage of the pediatric dental essential I	health benefit.
3—Reason for Enrollment/Change - Subscriber, please indicate the rea	ason for this enrollment or change.
○ New Hire ○ COBRA ○ Primary Care	Physician Remove Dependent Loss of Coverage
Open Enrollment Address/Phone Number Last Name	Retirement
Add Dependent Please indicate reason for adding dependent: Newt	oorn
4—Subscriber Information Adop	tion Obmestic Partner Change in Student Status
4—Subscriber Information Please complete both sides of this application. The subscriber sign	
Please complete both sides of this application. The subscriber sign Subscriber's Last Name	Subscriber's First Name M.I.
Please complete both sides of this application. The subscriber sign	ature is required in order to process the application.
Please complete both sides of this application. The subscriber sign Subscriber's Last Name	ature is required in order to process the application. Subscriber's First Name M.I. Telephone Number (include area code) Gender: Male
Please complete both sides of this application. The subscriber sign Subscriber's Last Name	ature is required in order to process the application. Subscriber's First Name M.I. Telephone Number (include area code) Gender: Female
Subscriber's Last Name Social Security Number Date of Birth (MMDDYY)	ature is required in order to process the application. Subscriber's First Name M.I. Telephone Number (include area code) Gender: Handle
Please complete both sides of this application. The subscriber sign Subscriber's Last Name Social Security Number Date of Birth (MMDDYY)	ature is required in order to process the application. Subscriber's First Name M.I. Telephone Number (include area code) Gender: Female Apt Suite Marital Status Single Married Divorced
Please complete both sides of this application. The subscriber sign Subscriber's Last Name Social Security Number Date of Birth (MMDDYY) Mailing Address	ature is required in order to process the application. Subscriber's First Name M.I. Telephone Number (include area code) Gender: Male Apt Suite Marrital Status Single Married Divorced
Please complete both sides of this application. The subscriber sign Subscriber's Last Name Social Security Number Date of Birth (MMDDYY) Mailing Address	ature is required in order to process the application. Subscriber's First Name M.I. Telephone Number (include area code) Gender: Female Apt Apt Suite Marital Status Single Married Divorced Legally Separated
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Please complete both sides of this application. The subscriber sign Subscriber's Last Name Social Security Number Date of Birth (MMDDYY) Mailing Address City State	Apt Suite Marital Status Single Apt Marital Status Divorced Egally Separated Widowed Marital Status Event Date (MMDDYY)
Subscriber's Last Name Social Security Number Date of Birth (MMDDYY) Mailing Address City State E-mail Address Medicare Eligible Please indicate reason for Medicare eligibility: Age 6	ature is required in order to process the application. Subscriber's First Name M.I. Telephone Number (include area code) Gender: Male Apt Suite Marrital Status Single Married Divorced E Zip Code Legally Separated Widowed Marrital Status Event Date (MMDDYY)

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Primary Care Physician's Last Name	First Nar	me					
Do you have additional group Name of Prior Health Care Insurer Policy Identification Number Policy Effective Date (MMDDY) Dependent Information Please provide all Information for each person to be covered. Spouse/Domestic Partner's Last Name Spouse/Domestic Partner's Social Security Number Date of Birth (MMDDYY) Are you enrolling as a I Are you enrolling as a I Primary Care Physician's Last Name Primary Care Physician's Last Name Primary Care Physician Number. Are you a current patient, or if not a current patient, have you verified that the PCP will accept Do you have additional group Jame of Prior Health Care Insurer Policy Identification Number Policy Identification Number Policy Identification Number Dependent's Last Name Dependent's First Name Dependent's First Name Dependent's First Name Dependent's Last Name Dependent's First Name Dependent's First Name Dependent's First Name Dependent's First Name Dependent a full-time student? Part A Effective Date (MMDDYY) Part B Effective Date (MMDYY) Part B Effective Date (MMDYY							
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Primary Care Physician Number: Are you a current patient, or if not a current patient, have you verified that the PCP will accept	t vou as a	a new na	atient?		Yes	\bigcirc	No
Do you have additional group	-			_	Yes	\bigcirc	No
f you answered "yes" to the question about stand-alone dental coverage in section 2, please provide the name o							1 41

5—Dependent Information continued										
Please provide all information for each p	erson to b	be covere	ed.							
Subscriber's Last Name				Subscriber'	s First Name	:				M.I.
Social Security Number	Date of	Birth (MMDI	DYY)							
Dependent's Last Name				Dependent	's First Name	;				M.I.
Social Security Number	Date of	Birth (MMDI	DYY)	Gende	r: Fe	emale	O Male			
				Is your	over-age dep	endent ha	andicapped	? 🔘	Yes	O N
E-mail Address										
Medicare Eligible Please indicate reason for M	ledicare eligi	ibility:	O Age	65+	Disability	○ End	d Stage Re	nal Dise	ease	
Medicare Number (if applicable)	Part A E	Effective Date	e (MMDDY	Y) PartBE	Effective Date (N	MMDDYY)	Part D Effec	ctive Date	e (MMDI	DYY)
Is dependent a full-time student?	O No	0	If yes, pl	ease indica	te college/un	iversity na	ıme:			
College/University Name						Exp	ected Gradu	ation Dat	e (MMD	DYY)
Primary Care Physician's Last Name				Primar	y Care Physi	cian's Firs	t Name			
Primary Care Physician Number: Are you a current patie	nt, or if not a c	current patien	ıt, have you	u verified that t	he PCP will acc	cept you as	a new patient	? 🔘	Yes	O N
			D	o you have	additional or	oun hoalth	ingurance	? ()	Yes	\bigcirc N
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ependent's Last Name	Dependent's F	First Name	M.I.
ocial Security Number	Date of Birth (MMDDYY) Gender:	Female Male	
·	Is your ov	ver-age dependent handicapped? Yes	\bigcirc
mail Address			
Medicare Eligible Please indicate reason for M	edicare eligibility: Age 65+	Disability	80
· ·	Part A Effective Date (MMDDYY) Part B Effec	, ,	
edicare Number (if applicable)	Patta Lilective Date (IVIIVIDD 11) Patta Lilec	ctive Date (MMDDYY) Part D Effective Date (MMDD	
dependent a full-time student? Yes	No If ves. please indicate of	college/university name:	
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