# New York
# Individual Enrollment Application

**Thank you for choosing Empire! Please mail us your completed application at:**
Empire BlueCross BlueShield
P.O. Box 659806
San Antonio, TX 78265-9106
Or Fax to: 1 (800) 848-2512

**IMPORTANT:** If you are a new applicant, your premium payment is required to be submitted with each application. If you are a current Individual policyholder with Empire BlueCross BlueShield, premium payment is required before your requested effective date. Please also complete the Payment Method for Individual Applications Form and send it with your completed enrollment application. If premium is not provided as described above, we will not process your application. If you have any questions while completing this application, please contact your insurance agent/broker directly. If you have not worked with an insurance agent/broker, please call 1 (877) 206-0915. If you have questions about a previously submitted application, please call 1 (855) 330-1104.

**Please complete in blue or black ink only.**

## Section A – Coverage Information

**Application Type (select one):**

☐ New Coverage ☐ Change policy coverage ☐ Add dependent(s) to current coverage

Policy No._____ Policy No._____

**Open Enrollment**
Once a year, Open Enrollment takes place for a set period. During the Open Enrollment period, you can apply for coverage, add members or change plans. The earliest Effective Date for the annual Open Enrollment period is the first day of the following calendar year. The actual Effective Date is determined by the date we receive your complete application and premium payment.

**We can accept applications ONLY during the Open Enrollment period UNLESS you have an event, that we call a "Qualifying Event" that gives you a Special Enrollment right.**

**No qualifying event is required to apply for new dental coverage.**

**For existing dental plan members, dental coverage changes and/or addition of dependents may only occur during the Open Enrollment period or if you experience a qualifying event. Following a qualifying event, an applicant has 60 days to submit an application.**

**To enroll outside of the Open Enrollment Period, you must have one of the following Qualifying Events and tell us about it <u>within 60 days before or after the event:</u>**

☐ You or your spouse or dependent involuntarily lost Minimum Essential Coverage (including COBRA or State continuation coverage); including if You are enrolled in a non-calendar year group health plan or individual health insurance coverage;
☐ You or your spouse or dependent are newly eligible for advance payments of the premium tax credit because the coverage you were enrolled in is no longer employer-sponsored Minimum Essential Coverage;
☐ You or your spouse or dependent lost eligibility for Medicaid coverage that covers primary or specialty care.

**To enroll outside of the Open Enrollment Period, you must have one of the following Qualifying Events and, except in the event of pregnancy, tell us about it <u>within 60 days after the event:</u>**

☐ You gained a dependent or became a dependent through marriage, birth, adoption or placement for adoption or foster care, or through a child support order or other court order (foster children are not eligible for coverage);
☐ You lose a Dependent or are no longer considered a Dependent through divorce, legal separation, or upon the death of You or Your Dependents; or
☐ You, your spouse or child moved and became eligible for new health plans;
☐ You, your spouse or child are newly eligible or newly ineligible for advance payments of the premium tax credit or had a change in eligibility for cost-sharing reductions on the NYS of Health Market Place (Exchange);
☐ You, your spouse's or child's enrollment or non-enrollment in another health plan was not intended or was an error caused by the error, misrepresentation, or inaction of another health plan or the Exchange;
☐ You, your spouse or child demonstrate another health plan in which you were enrolled substantially violated a material provision of its contract.
☐ You are pregnant as certified by your Health Care Professional. Subject to certification.

**Date of the Qualifying Event/Certification:** _____

If you are applying due to a Qualifying Event, your effective date is as follows:

- In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or Placement for adoption if we receive notice within 60 days of the event. Otherwise coverage begins on the date on which we receive notice. If you have individual or individual and spouse coverage, you must also notify us that you want to switch to parent and child/children or family coverage and pay any additional premium within 60 days of the event for coverage to start at the moment of birth; or
- In the case of marriage, loss of Minimum Essential Coverage, or becoming newly eligible for advance payments of the premium tax credit because your coverage is no longer employer-sponsored Minimum Essential Coverage, coverage is effective on the first day of the month following the date of the qualifying event.
- In the case of pregnancy, Coverage will be effective on the first day of the month in which you received the certification from your Health Care Professional that you are pregnant.
- If You, Your Spouse or Child enroll because of a court order, Your coverage will begin on the date the court order is effective.
- If You, Your Spouse or Child enroll because of the death of You or Your Dependents, Your coverage will begin on the first day of the month following Your selection; or
- In other cases, coverage effective date depends on when we receive your selection. If we receive it between the first and the 15th day of the month it will begin on the first day of the following month as long as you pay your premium. If we receive it between the 16th and last day of the month it will begin on the first day of the second month as long as you pay your premium.

**Section B – Applicant Information**

| Last Name | First Name | MI | Social Security Number* (required) |
|---|---|---|---|
| | | | |

| Home Address | | | |
|---|---|---|---|
| | | | |
| **City** | **State** | **ZIP** | **County** |
| | | | |
| **Billing Address (street and P.O. Box if applicable)** | | | |
| | | | |
| **City** | **State** | **ZIP** | |
| | | | |

| Marital Status<br>☐ Single ☐ Married | Sex<br>☐ M ☐ F | Date of Birth |
|---|---|---|
| | | |

| Primary Phone Number | Secondary Phone Number | E-mail |
|---|---|---|
| | | |

**Empire is required by the IRS to collect this information. It is used for internal purposes only and will not be disclosed unless you select the health savings account option in this Application or to federal and state agencies as required by applicable law.*

**Section C – Spouse or Domestic Partner to be Covered Information**

| Last Name | First Name | MI | Relationship<br>☐ Spouse ☐ Domestic Partner |
|---|---|---|---|
| | | | |

| Social Security Number* (required) | Sex<br>☐ M ☐ F | Date of Birth |
|---|---|---|
| | | |

**NOTE:** Spouses must have entered into a marriage legally recognized in the jurisdiction in which it is performed.

**Section D – Child Dependents to be Covered Information (All fields required. Attach a separate sheet if necessary).**

An eligible dependent is the natural or adopted child or stepchild of you or your spouse, and any proposed adoptive child who is dependent on you pending finalization of the adoption, to age 26. Over-age disabled dependent children may also qualify. See your policy for details.

Dependents are also eligible for coverage from ages 26 through 29 at extra cost without regard to financial dependence. The dependent must be unmarried, not insured by or eligible for coverage under an employer plan, AND live, work or reside in New York State. In order to extend coverage for young adults through age 29, see options under the Medical Coverage Section. Coverage of each child lasts until the end of the month in which the child no longer meets eligibility conditions.

| Last Name | First Name | MI | Sex | Date of Birth mm/dd/yyyy | Social Security Number* (required) | Relationship to Applicant |
|---|---|---|---|---|---|---|
| | | | M F<br>☐ ☐ | | | ☐ Child<br>☐ Other:_____ |
| | | | M F<br>☐ ☐ | | | ☐ Child<br>☐ Other:_____ |
| | | | M F<br>☐ ☐ | | | ☐ Child<br>☐ Other:_____ |
| | | | M F<br>☐ ☐ | | | ☐ Child<br>☐ Other:_____ |

**Empire is required by the IRS to collect this information. It is used for internal purposes only and will not be disclosed unless you select the health savings account option in this Application or to federal and state agencies as required by applicable law.*

**Do you have an unmarried dependent child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, or physical handicap and who became so incapable prior to attainment of the age at which the child's coverage would otherwise terminate and who is chiefly dependent upon you for support and maintenance?** ☐ **Yes** ☐ **No**

**If YES, a separate enrollment form (HAC 506) must be submitted to determine eligibility.**
☐ **Please send me a form (HAC 506).**

**Are all applicants listed on this application residents of the state in which you are applying for coverage?** ☐ **Yes** ☐ **No**
If **NO**, who? _____

**Preferred written language? (Optional)**
☐ English (ENG) ☐ Korean (KOR) ☐ Chinese (ZHO) (C/M) ☐ Spanish (SPN)

**Preferred spoken language? (Optional)**
☐ English (ENG) ☐ Korean (KOR) ☐ Chinese (ZHO) (C/M) ☐ Spanish (SPN)

## Section E – Medical Coverage

### Plan Name and Deductible/Coinsurance Options

**Select ONE Plan.**
Total Family Deductible is two (2) times the amount shown.

**All plans include Pediatric Dental Essential Health Benefits up to age 19.**

**Empire is licensed to operate in a 28 county service area in New York State. Applicants must live or reside in one of these counties to enroll: Albany, Clinton, Bronx, Columbia, Delaware, Dutchess, Essex, Fulton, Greene, Kings, Montgomery, Nassau, New York, Orange, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington, Westchester. You must be able to demonstrate, upon request, that you meet this requirement. PO Boxes are not accepted as a valid address.**

**HMO Bronze Plans**

**Empire HMO 6000 Bronze**
☐ **$6,000/20% (1H1F)**
☐ **$6,000/20% Dep Age 29 (1H1G)**

**Empire HMO 5850 Bronze**
☐ **$5,850/30% (1H1M)**
☐ **$5,850/30% Dep Age 29 (1H1N)**

**Empire HMO 5850 Bronze $0 PCP Office Visit**
☐ **$5,850/30% (1XK9)**
☐ **$5,850/30% Dep Age 29 (1XKA)**

**HMO Silver Plans**

**Empire HMO 2000 Silver**
☐ **$2,000/30% for Child Only (1H23)**
☐ **$2,000/30% (1H25)**
☐ **$2,000/30% Dep Age 29 (1H26)**

**Empire HMO 2250 Silver**
☐ **$2,250/25% (1H2V)**
☐ **$2,250/25% Dep Age 29 (1H2W)**

**HMO Gold Plans**

**Empire HMO 600 Gold**
☐ **$600/20% for Child Only (1H36)**
☐ **$600/20% (1H38)**
☐ **$600/20% Dep Age 29 (1H39)**

**Empire HMO 1000 Gold**
☐ **$1,000/10% (1H3E)**
☐ **$1,000/10% Dep Age 29 (1H3F)**

**HMO Platinum Plans**

**Empire HMO 0 Platinum**
☐ **$0/10% for Child Only (1H3R)**
☐ **$0/10% (1H3T)**
☐ **$0/10% Dep Age 29 (1H3U)**

**Empire HMO 250 Platinum**
☐ **$250/5% (1H45)**
☐ **$250/5% Dep Age 29 (1H46)**

**Catastrophic Plans (only available for Applicants under age 30, or otherwise qualified)**

**Empire HMO 6850 Catastrophic**
☐ **$6,850/0% (1H4A)**

**HSA Plans**

**Empire HMO 2750 for HSA Silver**
☐ **$2,750/10% (282C)**
☐ **$2,750/10% Dep Age 29 (281H)**

**Empire HMO 4000 for HSA Bronze**
☐ **$4,000/50% for Child Only (1H17)**
☐ **$4,000/50% (1H19)**
☐ **$4,000/50% Dep Age 29 (1H1A)**

☐ **YES**, I would like to establish a health savings account with the HSA-compatible health plan I selected. Please forward my information to Empire BlueCross BlueShield's banking partner. (Please fill in your social security number in Section B.)
☐ **NO, I DO NOT** want to establish a health savings account with the HSA-compatible health plan I selected above. Please **DO NOT** forward my information to Empire BlueCross BlueShield's banking partner.

If you select an HMO plan with the 0$ PCP OV Rider, please choose a Primary Care Physician for each family member from the Provider Directory, which can be found at www.empireblue.com, or by calling 1 (800) 331-0150. If you do not choose a PCP, then one will be selected for you.

| Applicant | Primary Care Physician (PCP) | PCP ID | Current Patient | PMG/IPA ID* |
|---|---|---|---|---|
| Primary Applicant | | | ☐ Yes ☐ No | |
| Spouse/ Domestic Partner | | | ☐ Yes ☐ No | |

| Applicant | Primary Care Physician (PCP) | PCP ID | Current Patient | PMG/IPA ID* |
|---|---|---|---|---|
| Dependent Name: | | | ☐ Yes ☐ No | |
| Dependent Name: | | | ☐ Yes ☐ No | |

**PMG = Participating Medical Group, IPA = Independent Practice Association*

☐ Please check box if any additional sheets of paper have been completed for this section. If so, please attach and return the additional sheets with this application.

## Section F – Dental and Vision Coverage

### Dental

☐ **Yes, I wish to purchase additional dental coverage to supplement the pediatric dental Essential Health Benefits available to enrollees to the end of the month they turn age 19 included in the medical plans above.**

**Select All that Apply:**

☐ **Empire BlueCross BlueShield Dental Family** - (1FUH)
☐ **Empire BlueCross BlueShield Dental Family Enhanced** - (1FUJ)
☐ **Dental Prime Plan A*** - (1RBK)
☐ **Dental Prime Plan B*** - (1RBL)
☐ **Dental Prime Plan C*** - (1RBM)

**Select who you are enrolling (applies to individuals listed on this application only):**

☐ Applicant only
☐ Applicant & Spouse or Domestic Partner only
☐ Applicant & all dependent children listed
☐ Applicant, Spouse or Domestic Partner, and all dependent children listed

*These plans do not include pediatric dental Essential Health Benefits that are required by the Affordable Care Act.

### Vision

Supplemental vision coverage is also available. In order to enroll in this coverage, you must enroll in at least one of the medical or dental coverage options in this application. If you have enrolled in one of the medical or dental plans and would like to add vision coverage, please select your plan option below.

☐ **Blue View Vision Individual*** - (1RYG)

**Select who you are enrolling (applies to individuals listed on this application only):**

☐ Applicant only
☐ Applicant & Spouse or Domestic Partner only
☐ Applicant & all dependent children listed
☐ Applicant, Spouse or Domestic Partner, and all dependent children listed

*These plans do not include pediatric vision Essential Health Benefits that are required by the Affordable Care Act.

## Section G – Other Health and Dental Coverage

1. Are you or anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ No
   If **YES**, who? _____
2. Are you or anyone applying for coverage currently receiving Social Security Disability, Medicare, Medicaid or other government program benefits, or unable to work due to disability or receiving Workers' Compensation benefits? ☐ Yes ☐ No
   If **YES**, who? _____
   _____
   Start date of benefits/coverage: ____/____/_____ End date of benefits/coverage: ____/____/_____
3. Do you or anyone applying for coverage, currently have dental coverage? ☐ Yes ☐ No

If **YES**, please provide the following for dental coverage:

| Name(s) of covered persons. If the whole family, simply write ALL in space below. | Identification Number(s) |
|---|---|
| Name and phone number of prior carrier(s) | |
| Type of coverage ☐ Group ☐ Individual | Effective Date of Coverage |
| Will you be terminating this dental coverage if approved for Empire Dental coverage? ☐ Yes ☐ No | If **YES**, what is the termination date? |

## Section H – Significant Terms, Conditions and Authorizations (TERMS)

**Please read this section carefully before signing the application.**

- I understand that although Empire BlueCross BlueShield requires payment with my application, sending my initial premium with this application, and the receipt of my payment by Empire BlueCross BlueShield, does not mean that coverage has been approved. I may not assign any payment under my Empire BlueCross BlueShield plan except as permitted by law. I am applying for the coverage selected on this application. I understand that, to the extent permitted by law, Empire BlueCross BlueShield reserves the right to accept or decline this application, and that no right whatsoever is created by this application. I understand that if my application is denied, my bank account or credit card will not be charged.

- I am responsible to timely notify Empire BlueCross BlueShield of any change that would make me or any dependent ineligible for coverage.

- I understand Empire BlueCross BlueShield may convert my payment by check to an electronic Automated Clearinghouse (ACH) debit transaction and that my original check will be destroyed. The debit transaction will appear on my bank statement although my check will not be presented to my financial institution or returned to me. This ACH debit transaction will not enroll me in any Empire BlueCross BlueShield automatic debit process and will only occur each time I send a check to Empire BlueCross BlueShield. Any resubmissions due to insufficient funds may also occur electronically. I understand that all checking transactions will remain secure, and my payment by check constitutes acceptance of these terms.

- By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Empire BlueCross BlueShield and myself.

- I understand I am applying for individual health and/or dental/vision coverage which is not part of any employer-sponsored plan. I understand that I am responsible for 100% of the premium payment and I am also responsible to ensure that premiums are paid.

- ☐ By checking this box, I authorize and expressly consent that Empire BlueCross BlueShield and its affiliated companies may send and deliver to me any communication that is not required to be provided to me by United States mail, including but not limited to legally required Plan Notices, policies, agreements, evidence of coverage booklets and underwriting, enrollment and billing and explanation of benefits statements, electronically, either by e-mail or via the Internet. Examples of documents that will not be sent by electronic means and will continue to be sent by U.S. Mail include notices of cancellation, notices of grace period, notices that will terminate your coverage, and notices regarding a denial of coverage. I understand that I can revoke this authorization or request paper copies at any time by contacting Empire BlueCross BlueShield customer service or online at www.empireblue.com.

- All statements and answers in this application are true, and are representations made to induce the issuance of coverage. Any, act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact found in this application may result in denial of benefits, rescission, or cancellation of my coverage(s).

- I certify each Social Security Number listed on this application is correct.

I give this authorization for and on behalf of any eligible dependents and myself if covered by Empire BlueCross BlueShield. I am acting as their agent and representative.
This application cannot be altered by the applicant after submission to Empire absent the acknowledgement and consent of Empire.

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. I have read, understand and agree to all the provisions set forth.

**SIGN HERE**

| | |
|---|---|
| Signature of Applicant* or Legal Representative<br><br>X | Date |
| Signature of Spouse or Domestic Partner or Dependent Child(ren) age 18 or over (if to be covered) or Legal Representative<br><br>X | Date |
| Signature of Dependent Child(ren) age 18 or over (if to be covered)<br><br>X | Date |

** (or Custodial Parent's or Guardian's signature if applicant is under age 18)*

**Section I – Agent/Broker Certification**

To be completed by your Empire BlueCross BlueShield-appointed agent/broker:
Did you see the proposed subscriber and spouse/domestic partner, if applying at the time this application was executed? ☐ Yes ☐ No

If **NO**, please explain: _____

**I certify to the best of my knowledge and belief, the responses herein are accurate.**

| | | | |
|---|---|---|---|
| Agent/Broker Signature<br><br>X | | | Date |
| Agent/Broker Name (please print) | | Agent/Broker Street Address/Suite No./Personal Mail Box (PMB) No. | |
| Agent/Broker ID/TIN | Agency ID/Parent TIN | City State ZIP | |
| Agent/Broker Phone No. | Agent/Broker Fax No. | Agent/Broker E-mail | |
| GA (if applicable) | | GA code (if applicable) | |

# Payment Methods for Individual Applications – New York

| Applicant / Member Name: | Primary Applicant's SSN: |
|---|---|
| | |

## Premium Payment is required. Please choose from Option 1 or 2

*Please Note: All Payments will be debited as soon as the date of enrollment.*

☐ **OPTION 1** – If you choose the following option for **INITIAL and FUTURE MONTHLY** payments, you are **NOT** required to make a selection from Option 2 for your initial payment.

☐ Monthly Automatic Premium Payment (complete Section A)

☐ **OPTION 2 –** If you did not select **OPTION 1**, please choose from the options below for your **INITIAL** premium payment. **If you choose one of these options, you will receive a bill every month thereafter which you will be responsible for payment.**

☐ Paper Check*
☐ Electronic Check (complete Section B)
☐ Credit / Debit Card (complete Section C)

**A. Monthly Automatic Premium Payment –** By providing your bank information, you authorize us to electronically debit your bank account. I understand this authorization will apply to all products selected. Subsequent premium amounts will be debited on the day you request below:

☐ Checking Account

☐ Savings Account
**(**You may need to contact your financial institution for routing and account number information.)


**Requested Debit Day**: _____ (1st to 6th of each month). If no date is requested, your premiums will be debited on the first of each month.

**Provide your Routing and Account Numbers here:**

| 9-Digit Bank Routing Number | Bank Account Number |
|---|---|
| | |

As a convenience to me, I request and authorize Empire Blue Cross and Blue Shield to pay and charge to my account checks drawn on that account by and made payable to the order of Empire Blue Cross and Blue Shield, provided there are sufficient collected funds in said account to pay the same upon presentation. I understand that the initial payment amount may vary as a result of change(s) during eligibility review, and/or subsequent payment amount may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, moving my residence, changing coverage and/or changes made by Empire Blue Cross and Blue Shield of which I am notified pursuant to my plan/policy. I agree that Empire Blue Cross and Blue Shield's rights with respect to each such debit shall be the same as if it were a check signed personally by me. I authorize Empire Blue Cross and Blue Shield to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Empire Blue Cross and Blue Shield premiums. This authority is to remain in effect until revoked by me by providing Empire Blue Cross and Blue Shield a 30-day written notice. I agree that Empire Blue Cross and Blue Shield shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, Empire Blue Cross and Blue Shield shall be under no liability whatsoever even though such dishonor results in forfeiture of coverage. **NOTE:** I understand that should Empire Blue Cross and Blue Shield's withdrawal not be honored by my bank, I will automatically be removed from Monthly Automatic Premium Payment and will be billed by mail. **I will incur a service charge for any withdrawal not honored.**

| Authorized Signature (as it appears in the financial institution's records) | Account Holder Name (Please PRINT) | Date |
|---|---|---|
| **X** | | |

**B. Electronic Check –** In lieu of sending a Paper Check, we can submit this same information electronically. We will need you to complete the information below. We require an exact amount to be debited.

| Account Holder Name (Please PRINT) | Bank Routing Number | Account Number | Amount |
|---|---|---|---|
| | | | $ |

**C. Credit / Debit Card -** As a convenience to me, I request and authorize Empire Blue Cross and Blue Shield to charge my card for a one time initial debit upon approval. I understand this authorization will apply to all products selected. I understand that the initial payment amount may vary as a result of change(s) during eligibility review and/or subsequent payment amounts may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, moving my residence changing coverage, and/or changes made by Empire Blue Cross and Blue Shield of which I am notified pursuant to my plan/policy. I agree that Empire Blue Cross and Blue Shield shall be fully protected in honoring any such card payments. I further agree that if any such card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, Empire Blue Cross and Blue Shield shall be under no liability whatsoever, including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of coverage. **Empire Blue Cross and Blue Shield accepts Visa ☐ and MasterCard ☐.**

Card Number:

Expiration Date:

Billing address for this Credit / Debit Card:

City:

Zip Code:

| Authorized Signature (as it appears on the credit card) | Cardholder Name (as it appears on the credit card – Please Print) | Date |
|---|---|---|
| **X** | | |

* When you provide a check as payment, you authorize Empire Blue Cross and Blue Shield either to use information from your check to make a one-time electronic funds transfer from your account or to process the payment as a check transaction. When Empire Blue Cross and Blue Shield uses this information from your check to make an electronic funds transfer, funds will be withdrawn from your account as soon as the date of coverage approval and you will not receive your check back from your financial institution.