EmblemHealth

TRANSACTION FORM FOR GROUP ACCOUNTS

I. SUBSCRIBER INFORMATION

Last Name	First Name	M.I.	Sex	Social Security Number

Street Address	Apt.	City	State	ZIP Code

Were you ever a member of EmblemHealth?
☐ NO ☐ YES
If YES, member ID _____

Marital Status:
☐ Single ☐ Married
☐ Domestic Partner

Birth Date:
Mo. Day Yr.

Home Tel. #: _____
Work Tel. #: _____
Cell Tel. #: _____

Email Address: _____
☐ **"GO PAPERLESS" and save trees (see back of form)***

Applicant's hours worked per week:
☐ at least 30 hours ☐ less than 30 hours ☐ COBRA

Type of Coverage: ☐ Individual ☐ Family ☐ Employee & Spouse/DP ☐ Employee & Child

Note: If electing Young Adult Coverage, please submit a completed Young Adult Election Form.

Primary Care Physician Name: (Not required for EPO/PPO members) _____ ID Number: _____

OB/GYN Selection Name: (Optional) _____ ID Number: _____

Are you covered by any other health insurance or Medicare?
☐ NO ☐ YES If YES, indicate:
Insurance Co. Name: _____
Insurance Co. Telephone #: _____ Type of Coverage: _____
Policy #: _____ Effective Date: _____

Check One:
☐ New Enrollment
☐ Reinstatement
☐ Termination
☐ Change to Ind.

Status:
☐ Add Dependent
☐ Remove Dep.
☐ Address Change
☐ Name Change

Transfer:
☐ To Another Carrier
☐ EmblemHealth Group Change:
From: _____
To: _____

II. ENROLLMENT INFORMATION — IF YOU ARE ENROLLING YOUR SPOUSE/DP AND/OR CHILDREN, PLEASE LIST EACH ONE BELOW — SEE ELECTION OF COVERAGE FOR ELIGIBILITY

Note: A birth/marriage certificate or 1040 Form will be required for spouse/dependents with different last name.

Last Name (if different)	First Name	Social Security Number	Sex	Relationship	Birth Date Mo.	Day	Yr.	✓ if Disabled[1]	Primary Care Physician Name/ID Number (Not required for EPO/PPO members)	OB/GYN Selection Name/ID Number (Optional)
DEPENDENT				☐ Spouse ☐ DP ☐ Child				☐		
Current Health Insurance Information:	Carrier Name: _____			Coverage Begin Date: _____				Coverage End Date: _____		
DEPENDENT				☐ Child				☐		
Current Health Insurance Information:	Carrier Name: _____			Coverage Begin Date: _____				Coverage End Date: _____		
DEPENDENT				☐ Child				☐		
Current Health Insurance Information:	Carrier Name: _____			Coverage Begin Date: _____				Coverage End Date _____		

[1]For dependent adult children incapable of self-sustaining employment, please see Section A on the back side of this form to check the appropriate "Add Dependent" box, and follow the instruction for required documentation.

Your signature is required to process this form. Your signature attests that you have read the reverse side of this form.
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 material fact associated with such application commits a fraudulent insurance act. Such act is a crime, and will be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Applicant must sign here: _____ **Date:** _____

III. EMPLOYER INFORMATION — THIS SECTION TO BE COMPLETED BY EMPLOYER/CONTRACTOR GROUP

Name of Group:	Group Number:	☐ EmblemHealth ☐ GHI ☐ GHI HMO ☐ HIP Plan Name: _____	If you selected a small group metal plan, please check which type: ☐ Gold ☐ Silver ☐ Bronze
Requested Effective Date: Medical: _____ Dental: _____	Hire Date:	Waiting Period:	Date Submitted: / Approved By: (Group Plan Administrator)

Instructions to Benefit Administrators or Group Representatives: For groups with 50 employees or fewer, you MUST complete Section A on the reverse sice of this form. Required documentation MUST be attached to this Transaction Form to be processed.