APPLICATION FOR INDIVIDUALS
OFF-EXCHANGE DIRECT PAY EPO

EmblemHealth®

INSTRUCTIONS

- Please type or print firmly with ballpoint pen.
- This is an application that may be used to apply for new enrollment, or to change your type of contract. Complete this application if you or your spouse, or both, are not eligible for Medicare due to age. Your contract should be appropriate (Individual, Family, Child Only) to your status as indicated below:
  - Individual
    - If you are unmarried, widowed, divorced, or legally separated and have no dependent children.
    - If you are married without dependent children, and each spouse would prefer their own individual contract.
  - Family
    - If you are married, or if you are married with dependent children. If you are married and your spouse is eligible for Medicare, and you have one or more dependents under age 26, you should apply for a Family contract for you and your child(ren). Your Medicare-eligible spouse should apply for separate coverage using a Non-Group Medicare Supplement Insurance Application Form.
    - If you are unmarried, widowed, divorced, or legally separated with one or more dependent children.
    - If you have one or more dependent children under 26 years of age, complete only one application for Family coverage for yourself and your children.
  - Child Only
    - If you are purchasing coverage for a child only – this contract will not provide coverage for the Responsible Adult
    - If you are the Responsible Adult for a child under 21 years of age. Children covered under this contract include natural children, legally adopted children, step children, children for whom the Responsible Adult is the proposed adoptive parent, and children for whom the Responsible Adult is the legal guardian. Foster children and grandchildren of the Responsible Adult are not covered.
    - If you would like to purchase a Child Only contract for more than one child, please complete a separate application for the additional child(ren).
- When submitting your completed application a check or money order is required with your application.
- All applicants must:
  1. Complete, sign, and date the application where indicated.
  2. Check the appropriate boxes for type of coverage and type of contract.
  3. Return the completed application with your check or money order to:
     EmblemHealth
     ATTN: IND DM
     Sales Direct Pay
     55 Water Street 4th Floor
     New York, NY 10041-8190

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.

PRINT IN INK

Type of Contract: ❒ Individual Contract ❒ Family Contract (Individual/Spouse & Child(ren)) ❒ Individual & Spouse ❒ Parent & Child(ren) ❒ Child Only

1. Insured Information - Please complete the following information for the Insured.

Full Name	Sex ❒ Male ❒ Female	Date of Birth (M/D/Y)	Social Security Number
Home Address (P.O. Box is not acceptable)		Telephone Numbers Home: Work: Cell:	
City	County	State	Zip Code
Mailing Address (If different from Home Address)			
City	County	State	Zip Code
Applicant E-mail Address	❒ "Go Paperless" and Save Trees! (see below)		Primary Language Spoken

2. Child Only Contract Responsible Adult Information - Please complete the following information for the Responsible Adult if you've selected a Child Only Contract

Full Name	Relationship to Child	Telephone Numbers Home: Work: Cell:	
Home Address (P.O. Box not Acceptable)		E-Mail Address	
City	County	State	Zip Code
Billing Address (If different from Home Address)			
City	County	State	Zip Code

3. Family Contract Only – Please complete the information below for spouse and/or dependent child(ren) to be covered under the GHI Plan. A dependent child will be covered until the end of the month in which he/she becomes 26 years of age. The Age 29 Rider will extend dependent child coverage to the end of the month he/she becomes 30 years of age and is available for purchase – please refer to the included rate sheet. Check the box below if your listed dependent child(ren) require the purchase of the Age 29 Rider.

❒ Purchase Age 29 Rider

Last Name	First Name	M.I.	DOB M/D/Y	Social Security Number	Sex	Relationship	Mailing Address (If different from above)	Email Address	Telephone (Daytime)

4. Please enter the plan you would like to purchase. For PLAN SELECTION see attached rate sheet for applicable rates.

PLAN SELECTION:

Please specify Plan _____ Requested Plan start date: _____

Have you obtained stand-alone dental coverage that provides a pediatric dental essential health benefit through a New York State of Health Exchange-certified stand-alone dental plan offered outside the New York State of Health Exchange? ❒ Yes ❒ No

If you answered "yes", please provide the name of the company issuing the stand-alone dental coverage: _____

If you answered "no" we will provide you coverage of the pediatric dental essential health benefit. This dental coverage is underwritten by DentCare. DentCare is not an EmblemHealth company.

By electing "Go Paperless," you will receive claim statements and other communications from EmblemHealth in your secure online message center instead of paper mail. You will be able to view your Explanation of Benefits (EOBs) under the Claims portal of the EmbleamHealth website. Your enrollment in the "Go Paperless" option will continue as long as your account remains active, or until you choose to discontinue this option.

	If you are applying for individual coverage, and if your spouse is eligible for Medicare, check here. ❒
5.	**If you are presently enrolled under a GHI Direct Payment Hospital/Medical Plan, please check the appropriate box below.**
	❒ I wish to change my present coverage from Individual to Family. ❒ I wish to change my present coverage from Family to Individual

I hereby apply for the (specify Plan Selection) _____

If this application is for a family contract, I have provided the names of my spouse and dependent children under 26 years of age. If I have selected to purchase the Age 29 Rider I have included those dependent children under 29 years of age. I make this application on their behalf as well as my own.

I represent and understand that:

A. On my enrollment date, my existing contract(s), if any, will be canceled.

B. All statements and answers in this application are true to the best of my knowledge and belief. This application will be made part of my contract(s).

NOTE: BEFORE DATING AND SIGNING THIS APPLICATION. PLEASE MAKE SURE YOU HAVE ANSWERED ALL THE QUESTIONS. ALSO, BE SURE YOU HAVE CHECKED THE APPROPRIATE BOX FOR TYPE OF COVERAGE YOU DESIRE.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim concerning any materially false information, or conceals for the purposes 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

Applicant's Signature (Do Not Print) Date Signed

Applicant's Spouse's Signature (Do Not Print) Necessary Only When Applying For Family Coverage Date Signed

EmblemHealth Website

For fast, convenient access to the latest claim status, eligibility, and benefits information, visit EmblemHealth's secure website at **emblemheatth.com**. Available around the clock, the site offers provider listings, enables you to order ID cards, view an online Explanation of Benefits, access wellness information, and much more.

Translation Services

If English is not your primary language and translation services are needed when calling GHI Customer Service, a representative can help you.

(For GHI Office Use Only)

	(Initials)	(Initials)
Date Application Issued	_____	_____
Date Application Received	_____	_____
Date Application Processed	_____	_____
Date, Contract and Copy of Application Sent	_____	_____
Type of Plan	_____	_____
Group Number	_____	_____
Category Number	_____	_____
Effective Date	_____	_____