# APPLICATION FOR INDIVIDUAL OFF-EXCHANGE DIRECT PAY HMO

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.
  - If your spouse is Medicare eligible and even if you have dependents under the age of 26 and do not wish to purchase a policy that covers dependents.

  –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're covering 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 and you're covering 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 each additional child.
- 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 credit card information, a check or money order to (a postage paid envelope is enclosed):

     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

**Plan Selection:** (For plan selection see attached rate sheet for applicable rates.)
**Please specify Plan** (Bronze, Silver, Gold, Platinum, Platinum POS or Catastrophic): _____ Requested Plan start date: _____

**1. Please complete the following information for the subscriber.**

| 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:<br>Work:<br>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) | | |

**2. Please complete the following spouse and/or dependent child(ren) information if applying for a Family Contract.**
**A dependent child will be covered until the end of the month in which he/she becomes 26 years of age.**

| 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) |
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**3. The Responsible Adult must complete the following child only information if applying for a Child Only Contract.**
**A child will be covered until the end of the year in which he/she becomes 21 years of age.**

| Dependent 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) |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
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**By electing "Go paperless," you will receive claim statements and some other EmblemHealth letters by e-mail instead of paper mail. You will be able to view your Explanation of Benefits (EOBs) under the Claims portal of the EmblemHealth Web site. Your enrollment in the "Go Paperless" option will continue as long as your account remains active, or until you choose to discontinue this option.**

**4.** **Please provide the following information for your current or prior health benefits plan (if any).**

| Type of Plan | Name and Address of Insurer | Telephone Number of Insurer | Name of Policyholder | Policy I.D. Number | Effective Date of Prior Policy | Termination Date of Prior Policy |
|---|---|---|---|---|---|---|
| Hospital | | ( ) | | | | |
| Medical | | ( ) | | | | |

**5.** Primary Care Physician (PCP) | PCP ID Number

**6.** **Do you intend to replace an existing accident and health insurance policy or coverage with the HIP Plan you are now applying for?** ❒ No ❒ Yes
**If yes, termination date of your other insurance / / .**
**If yes, please check the type of plan you intend to replace.** ❒ **Hospital Insurance** ❒ **Medical Insurance** ❒ **Other (Please specify)** _____

**7.** **Are you eligible for group coverage that is comparable to the HIP coverage you are applying for in this application?** ❒ Yes ❒ No

Please explain: _____

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

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

If you answered "no", you are required to purchase pediatric dental coverage from an approved stand-alone pediatric dental carrier. Healthplex, Inc. can provide you the required pediatric dental essential health benefit coverage.

**If you are applying for individual coverage, and if your spouse is eligible for Medicare, check here.** ❒

**9.** **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. Please check the box and complete the information below if the dependent child(ren) require the purchase of the Age 29 Rider.**

❒ **Purchase Age 29 Rider**

| Dependent 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) |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
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**PLEASE SUBMIT PAYMENT WITH THIS APPLICATION IN THE ATTACHED POSTAGE PAID ENVELOPE.**

**10.** **If you are presently enrolled under a HIP Direct Payment Hospital/Medical Plan and want to change your enrollment status, 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 child(ren) under 26 years of age. If this application is for child only coverage, as the responsible adult I have provided the child(ren) under 21 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.

When the application is processed, coverage will be effective only if payment is received in accordance with the invoice. 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.

**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

Responsible Adult's Signature (Do Not Print) Necessary Only When Applying For Child Only Coverage Date Signed

**EmblemHealth Web Site**

For fast, convenient access to the latest claim status, eligibility, and benefits information, visit EmblemHealth's secure Web site at **www.emblemhealth.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 HIP Customer Service, a representative can help you.

**(For HIP 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 | _____ | _____ |
| Benefit Set ID | _____ | _____ |
| Effective Date | _____ | _____ |