

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? <input type="checkbox"/> NO <input type="checkbox"/> YES If YES, member ID _____	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner (DP)	Birth Date: Mo. Day Yr.	Home Tel. #: _____ Work Tel. #: _____ Cell Tel. # (see back of form*): _____	Email Address: _____
Applicant's hours worked per week: <input type="checkbox"/> At least 20 hours <input type="checkbox"/> Less than 20 hours <input type="checkbox"/> COBRA <input type="checkbox"/> Retiree (see back of form**)		Type of Coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Employee & Spouse/DP <input type="checkbox"/> Employee & Child		Note: If electing Young Adult Coverage, please submit a completed Young Adult Election Form.

Primary Care Physician Name: (Not required for EPO/PP0 members) _____ ID Number: _____

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

Are you covered by any other health insurance or Medicare? <input type="checkbox"/> NO <input type="checkbox"/> YES If YES, indicate: Insurance Co. Name: _____ Insurance Co. Telephone #: _____ Type of Coverage: _____ Policy #: _____ Effective Date: _____	Check One: <input type="checkbox"/> New Enrollment <input type="checkbox"/> Reinstatement <input type="checkbox"/> Termination <input type="checkbox"/> Change	Status: <input type="checkbox"/> Add Dependent <input type="checkbox"/> Remove Dep. <input type="checkbox"/> Address Change <input type="checkbox"/> Name Change	Transfer: <input type="checkbox"/> To Another Carrier <input type="checkbox"/> EmblemHealth Group Change: From: _____ To: _____
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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			✓ if Disabled ¹	Primary Care Physician Name/ID Number (Not required for EPO/PP0 members)	OB/GYN Selection Name/ID Number (Optional)
					Mo.	Day	Yr.			
DEPENDENT				<input type="checkbox"/> Spouse <input type="checkbox"/> DP <input type="checkbox"/> Child						
Current Health Insurance Information: Carrier Name: _____ Coverage Begin Date: _____ Coverage End Date: _____										
DEPENDENT				<input type="checkbox"/> Child						
Current Health Insurance Information: Carrier Name: _____ Coverage Begin Date: _____ Coverage End Date: _____										
DEPENDENT				<input type="checkbox"/> Child						
Current Health Insurance Information: Carrier Name: _____ Coverage Begin Date: _____ Coverage End Date: _____										

¹For 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 NYC DEPUTY SHERIFF BENEVOLENT ASSOCIATION	Group Number: 11243960	Sub Group ID: 1001	Class ID: 1001	Plan ID: DP010227	<input type="checkbox"/> HIP <input type="checkbox"/> GHI <input type="checkbox"/> HIPIC
If you selected a small group metal plan, please indicate which plan you are selecting: _____					Plan Name: N/A
Requested Effective Date: Medical: N/A Dental: <input checked="" type="checkbox"/>	Hire Date: _____	Waiting Period: NONE	Date Submitted: _____	Approved By: (Group Plan Administrator) _____	

Instructions to Benefit Administrators or Group Representatives: For groups with 100 or fewer full-time equivalent eligible employees, you MUST complete Section A on the reverse side of this form. Required documentation MUST be attached to this Transaction Form to be processed.

IMPORTANT INFORMATION

1. The subscriber must complete sections I and II. The group plan administrator must complete section III, and if for a small group (100 or fewer full-time equivalent eligible employees) provide all necessary documentation.
2. All transactions are subject to EmblemHealth's retroactive enrollment period – members must be enrolled within 30 days (for small groups) or 90 days (for large groups) from the Qualifying Event.
3. As part of New York State's "Age 29" law, eligible young adults through age 29 may obtain coverage through a parent's group policy.
4. Failure to complete any part of this form (e.g., group number, reason for submission, certificate number, signature, etc.) will require EmblemHealth to return this transaction form to the employer group plan administrator and may delay the requested effective date of coverage.
5. Return the completed Transaction Form along with any required documentation to: Membership, PO Box 2820, New York, NY 10116-2820.

Get more information at www.emblemhealth.com.

SECTION A

(To be completed by Benefits Administrator)

ACTION Check (✓)One	Qualifying Event	Documentation Required
<input type="checkbox"/> Add Subscriber	New Hire or Change in Plan	For eligible employees who work at least 30 hours per week, provide a recent Copy of NYS-45 showing this subscriber as an employee or provide copy of payroll documentation reflecting the date, employee's name and Social Security #, or the employee's current-year W-4 Form.
<input type="checkbox"/> Add Spouse	Marriage	If last name is different <input type="checkbox"/> Marriage Certificate <input type="checkbox"/> 1040 Form
<input type="checkbox"/> Add Dependent	Birth or Adoption	If last name is different <input type="checkbox"/> Birth Certificate <input type="checkbox"/> Formal Adoption Papers <input type="checkbox"/> Court-Approved Guardianship Papers
<input type="checkbox"/> Add Young Adult	Young Adult Coverage	Young Adult Election Form
<input type="checkbox"/> Add Dependent	Dependent Adult Child Incapable of Self-Sustaining Employment	Disability Status Request Form
<input type="checkbox"/> Add Spouse <input type="checkbox"/> Add Dependent	Loss of Coverage	Certificate of Creditable Coverage
<input type="checkbox"/> Add Domestic Partner	Domestic Partnership	Declaration of Cohabitation & Financial Interdependence Form

Note: No exceptions to our retroactive enrollment period will be allowed. Small group members must be enrolled within 30 days from the Qualifying Event/next billing date (or within 90 days for large group members).

*I understand that the phone number(s) I provided on this form may be used by EmblemHealth or any of its contracted parties to contact me about my account, my health benefit plan or related programs, or services provided to me.

** Retiree option is applicable for large groups only.