



TRANSACTION FORM FOR GROUP ACCOUNTS



I. SUBSCRIBER INFORMATION

Last 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

Telephone #: Home: (____) _____ Work: (____) _____
 Birth Date: Mo. Day Yr. _____

E-Mail Address: _____
 "GO PAPERLESS" and save trees (see back of application)*

Young Adult Coverage: 26 And Under --- Family 26 - 29 --- Single Parent ID: _____
 Subscriber Employment Status: _____
 Applicant working at least 20 hours per week

Primary Care Physician Name: (Not required for EPD/PPD members) _____
OB/GYN Selection Name: (Optional) _____
 ID Number: _____

Prior Health Insurance Information:
 Carrier Name: _____
 Coverage Begin Date: ____/____/____
 Coverage End Date: ____/____/____

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

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

Last Name (if different)	First Name	Social Security Number	Sex	Relationship	Birth Date		✓ if Disabled	Primary Care Physician Name/ID Number (Not required for EPD/PPD members)	OB/GYN Selection Name/ID Number (Optional)
					Mo.	Day			
DEPENDENT				<input type="checkbox"/> Spouse <input type="checkbox"/> DP <input type="checkbox"/> Child					
DEPENDENT				<input type="checkbox"/> Child					
DEPENDENT				<input type="checkbox"/> Child					
DEPENDENT				<input type="checkbox"/> Child					

Current/Prior Health Insurance Information: Carrier Name: _____ Coverage Begin Date: ____/____/____ Coverage End Date: ____/____/____

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

Your signature is required to process this form. Your signature attests that you have read the reverse side of this form.

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 Family
 Individual Employee & Spouse/DP Employee & Child

Requested Effective Date: _____ Hire Date: _____
 Medical: ____/____/____ Dental: ____/____/____
 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 side of this form. Required documentation MUST be attached to this Transaction Form to be processed.

ELECTION OF COVERAGE

Pre-existing conditions will not be covered during the first 12 months of enrollment in the EmblemHealth Comprehensive program or during the first 11 months of enrollment in the EmblemHealth EPO, EmblemHealth PPO, EmblemHealth ConsumerDirect PPO or EmblemHealth ConsumerDirect EPO plans. For policies issued or renewed after September 23, 2010, pre-existing condition limitations will be waived for enrollees under age 19. A pre-existing condition is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice of treatment was recommended or received during the six-month period prior to your enrollment date. EmblemHealth will credit the time you were covered by prior creditable health insurance coverage toward the 12-month or 11-month period, as long as the break in coverage between the prior coverage and your EmblemHealth coverage does not exceed 63 days, exclusive of any waiting periods. If requested, you or your group must provide EmblemHealth with information about your pre-existing conditions and/or previous coverage. You have the right to request a Certificate of Creditable Coverage from your prior health plan. If needed, EmblemHealth will help you get such a certificate from your prior plan.

A large group (51 or more eligible employees) may elect to cover pre-existing conditions from the start of your EmblemHealth coverage. In such a case, your EmblemHealth policy will not contain a pre-existing condition limitation or it will state that the pre-existing condition limitation does not apply.

Please call EmblemHealth at 1-877-842-3625 for more information about a pre-existing condition limitation.

IMPORTANT INFORMATION

- The subscriber must complete sections I and II. The group plan administrator must complete section III and if for a small group (50 employees or fewer), provide all necessary documentation.
- All transactions are subject to EmblemHealth's retroactive policy (30 days for small groups, 90 days for large groups).
- For policies issued or renewed after September 23, 2010, dependent children may stay on or be added to a parent's policy until age 26 (end of birthday month), regardless of student status, as part of federal health reform. The premium will be billed at the applicable coverage tier and, other than the basic enrollment form, nothing else is required. Most employer groups cannot limit dependent coverage eligibility even if the qualified dependent has access to his or her own employer-based coverage. Only standard GHI and HIP HMO Direct Pay, Healthy New York and GHI large groups have the possibility of restrictions for adding dependents up to age 26. As part of New York State's "age 29" law, eligible young adults through age 29 (up to 30th birthday) may continue or obtain coverage through a parent's group policy.
- 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.

Effective September 23, 2010, federal health reform may require changes to your coverage, depending on your plan. Get more information at www.emblemhealthreform.com.

*** 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 section 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.**

DOCUMENTATION BASED ON GROUP SIZE

Group Type (Check One) 

ACTION Check (✓)One	Qualifying Event	Documentation Required	<input type="checkbox"/> Sole Proprietorship or One-Subscriber Group	<input type="checkbox"/> Association of Two or More Employees	<input type="checkbox"/> Small Group — Less than 50 Employees
<input type="checkbox"/> Add Subscriber	New Hire or Change in Plan	For eligible employees who work more than 20 hours weekly, provide a recent Copy of NYS45 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 W4 form.	Not Eligible		
<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 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 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	Not Eligible	Not Eligible	

Note: No Retroactive Enrollments will be allowed. Members must be enrolled within 30 days from the Qualifying Event/next billing date.

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