

HIP HEALTHY NEW YORK EMPLOYEE ENROLLMENT APPLICATION

Social Security Number:										
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PLEASE PRINT

Last Name			First Name			MI	Sex
Street Address (Number)			Apt.	City		State	ZIP Code
Were you ever a member of HIP? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, indicate policy number: _____			Birth Date Mo Day Yr.		Telephone No. Home: (____) _____ Work: (____) _____ E-Mail Address: _____		
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced		Date of Event Mo Day Yr.		Are you covered by any other Health Insurance? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, indicate: Insurance Co. Name: _____ Address: _____ Policy No.: _____ Effective Date: _____		Is your spouse covered by any other Health Insurance? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, indicate: Insurance Co. Name: _____ Address: _____ Policy No.: _____ Effective Date: _____	
Primary Care Physician: <input type="checkbox"/> Internal <input type="checkbox"/> Pediatrics <input type="checkbox"/> Family Practice Physician Name: _____ Physician No.: _____			* If you are applying for coverage for your spouse and/or children, please list each below – see Election of Coverage for eligibility. In case of emergency, please contact: Name: _____ Relation: _____ Telephone: Home: (____) _____ Work: (____) _____				

Last Name (if different)	First Name	Social Security No.	Sex	Relationship	Birth Date			Check if over 19 or disabled	Physician Name or No.
					Mo	Day	Yr.		
SPOUSE:									
ADDITIONAL DEPENDENTS: (List oldest first)									

PLEASE INDICATE ADDITIONAL DEPENDENTS ON A DUPLICATE SHEET

ELECTION OF COVERAGE AND AUTHORIZATION

I am applying for coverage for myself, my spouse and eligible children. I select for myself and my family members, if any, the Medical Group/Network Physician named above, to serve as my/our Primary Care Physician (PCP). On behalf of myself and each eligible Family Member, I hereby authorize all physicians, nurses, hospitals and other providers who or which have, at any time, either before or after we became covered by HIP, provided any diagnosis, treatment or any other service to any of us, to furnish HIP and our Medical Group/Network Physician all information and records relating thereto.

I understand that for members nineteen (19) and over, pre-existing conditions will not be covered during the first 12 months of the contract. A pre-existing condition is a condition (whether physical or mental), regardless of the cause of the condition for which medical advice, diagnosis, care or treatment was recommended by a duly licensed medical professional or received within the six (6) month period ending on the enrollment date. Pregnancy existing on the enrollment date of this coverage is considered a pre-existing condition for a period not to exceed ten (10) months. Genetic information may not be treated as a pre-existing condition in the absence of diagnosis of the condition related to such genetic information. However, if I/we had Creditable Coverage continuously to a date not more than sixty-three (63) days before the enrollment date of this coverage, HIP will credit the time I/we were covered for the partial satisfaction of a pre-existing condition limitation. If I/we had Creditable Coverage for 12 months or longer, I/we will not be subject to a pre-existing condition limitation if the Creditable Coverage was continuous to a date not more than sixty-three (63) days before the enrollment date under the coverage. I/we agree that after enrolled for this coverage, upon request I/we will provide HIP and/or my physician with information about any pre-existing condition(s) and previous coverage I/we had. Benefits for pre-existing conditions are not payable until we receive a copy of your Certificate of Creditable Coverage or proof of your prior coverage.

All information provided above is true and complete to the best of my knowledge. A copy of the application will be placed in my HIP medical record.

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 purposes of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

All applicants must sign below. HIP CHOICE PLUS applicants please note that HIP CHOICE PLUS program is provided under the two separate contracts: an HIP/HMO Contract issued by the Health Insurance Plan of Greater New York and CHOICE PLUS contract issued by the HIP Insurance Company of New York. Both contracts will end simultaneously if your HIP CHOICE PLUS coverage ends.

All applicants sign here: _____ **Date:** _____

TO BE COMPLETED BY EMPLOYER

Name of Group		Group Number		Coverage: <input type="checkbox"/> HIP <input type="checkbox"/> HIP/HMO <input type="checkbox"/> HIP CHOICE PLUS <input type="checkbox"/> Individual <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Child <input type="checkbox"/> Family	
Requested Effective Date	Date Submitted to HIP	Approved by (Representative of Employer/Contractor)		FOR HIP USE ONLY	
			Processed by		Date