APPLICATION FOR INDIVIDUALS

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) 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.
- When submitting your completed application a check or money order is required with your application.
- All applicants must:
  - Complete, sign, and date the application where indicated.
  - Check the appropriate boxes for type of coverage and type of contract.
  - 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

1 Please complete the following information for the applicant

Full Name of Applicant	Sex ☐Male☐Female	Date of Birth (M/D/Y)	Social Security Number
Home Address (P.O. Box is not Acceptable)		Telephone Numbers:	Home: Work:
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 information if applying for a Family Contract.

Full Name (Spouse)	Sex ☐Male☐Female	Date of Birth (M/D/Y)	Social Security Number
Home Address (P.O. Box is not Acceptable)		Telephone Numbers:	Home: Work:
City	County	State	Zip Code
Mailing Address (If different from Home Address)			
City	County	State	Zip Code
E-Mail Address			

3 Please provide the following information for your current or prior health benefits plan.

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						

4 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. ☐Hospi Insurance ☐Medical Insurance ☐Other (Please specify)

5 Please complete the information below for each dependent child to be covered under the HIP 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

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)

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.

6	**Are you eligible for group coverage that is comparable to the HIP coverage you are applying for in this application?** ☐No ☐Yes **Please explain:** _____
7	**Has your health insurance coverage been terminated within the last 12 months due to nonpayment of premiums?** ☐No ☐Yes
8	**Please check the appropriate box below. For the TYPE OF CONTRACT your selection must be in accordance with your marital status, as outlined in the instructions at the top of the previous page. For PLAN SELECTION see rate sheet for applicable rates.** **TYPE OF CONTRACT:** **Individual☐** **Family ☐** **PLAN SELECTION:** **Please specify Plan:** _____ **Requested Plan start date:** _____
9	**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" Healthplex, Inc. will provide you coverage of the pediatric dental essential health benefit. This dental coverage is underwritten by Healthplex, Inc. and is not an EmblemHealth company.**
	If you are applying for individual coverage, and if your spouse is eligible for Medicare, check here.☐
	PLEASE DO NOT SUBMIT PAYMENT WITH THIS APPLICATION.
10	**If you are presently enrolled under a HIP 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 ☐

IF YOUR CONTRACT IS TERMINATED BECAUSE YOU DID NOT PAY PREMIUMS, YOU CANNOT PURCHASE HEALTH INSURANCE FROM HIP FOR 12 MONTHS AFTER THE DATE OF TERMINATION.

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.

When the application is processed, coverage will be effective only if payment of the subscription charges 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. 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 Web Site

For fast, convenient access to the latest claim status, eligibility, and benefits information, visit EmblemHealth's secure Web site at www.emblemheatth.com. Available around the clock, the site offers provider listings, enables you to order 10 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		

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