Health Insurance Application
INDIVIDUAL

HEALTH REPUBLIC
INSURANCE OF NEW YORK

1. APPLICANT INFORMATION

Last Name _____ First Name _____ M.I. ____ Gender ❑ Female ❑ Male

Date of Birth (mm/dd/yy) _____ Social Security Number _____

Home Phone _____ Daytime Phone _____

Marital Status ❑ Single ❑ Married ❑ Domestic Partner E-Mail _____

Are you enrolled in Medicare? ❑ Yes ❑ No If "Yes", Effective Date ____/____/____ ❑ Part A ❑ Part B ❑ Part D

Street Address _____ Apt. _____

City _____ State _____ Zip _____

County _____

2. INSURANCE INFORMATION

Plan Start Date: / 01 / (mm/01/yy)

MUST BE 1ST OF MONTH

SELECT A PLAN:

EssentialCare

- ❑ EssentialCare Bronze Plan
- ❑ EssentialCare Silver Plan
- ❑ EssentialCare Gold Plan
- ❑ EssentialCare Platinum Plan

- ❑ EssentialCare Bronze Plan 29
- ❑ EssentialCare Silver Plan 29
- ❑ EssentialCare Gold Plan 29
- ❑ EssentialCare Platinum Plan 29

- ❑ EssentialCare Bronze Plan CHILD-ONLY PLAN
- ❑ EssentialCare Silver Plan CHILD-ONLY PLAN
- ❑ EssentialCare Gold Plan CHILD-ONLY PLAN
- ❑ EssentialCare Platinum Plan CHILD-ONLY PLAN

PrimarySelect

- ❑ PrimarySelect Bronze Plan
- ❑ PrimarySelect Silver Plan
- ❑ PrimarySelect Gold Plan
- ❑ PrimarySelect Platinum Plan

- ❑ PrimarySelect Bronze Plan 29
- ❑ PrimarySelect Silver Plan 29
- ❑ PrimarySelect Gold Plan 29
- ❑ PrimarySelect Platinum Plan 29

PrimarySelect PCMH

- ❑ PrimarySelect PCMH Silver Plan
- ❑ PrimarySelect PCMH Silver Plan 29

TotalIndependence

- ❑ TotalIndependence Bronze Plan
- ❑ TotalIndependence Silver Plan
- ❑ TotalIndependence Gold Plan

- ❑ TotalIndependence Bronze Plan 29
- ❑ TotalIndependence Silver Plan 29
- ❑ TotalIndependance Gold Plan 29

- ❑ TotalIndependence Bronze Plan CHILD-ONLY PLAN
- ❑ TotalIndependence Silver Plan CHILD-ONLY PLAN
- ❑ TotalIndependence Gold Plan CHILD-ONLY PLAN

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",** please be aware that such coverage is required in New York State. Through an arrangement with Health Republic Insurance of New York, Solstice Health Insurance Company will provide you this coverage, and bill you separately. Please visit healthrepublic.mysolstice.net. If you have any questions, please call us at 888-990-5702.

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3. DEPENDENT INFORMATION

SPOUSE/DOMESTIC PARTNER:

Last Name _____ First Name _____ M.I. ____ Gender ❑ Female ❑ Male

Date of Birth *(mm/dd/yy)*_____ Social Security Number _____ Relationship ❒ Spouse ❒ Domestic Partner

Is this dependent enrolled in Medicare? ❑ Yes ❑ No If "Yes", Effective Date ____/____/____ ❑ Part A ❑ Part B ❑ Part D

Email_____ Home Phone _____

DEPENDENT 1:

Last Name _____ First Name _____ M.I. ____ Gender ❑ Female ❑ Male

Date of Birth *(mm/dd/yy)*_____ Social Security Number _____

Is this dependent enrolled in Medicare? ❑ Yes ❑ No If "Yes", Effective Date ____/____/____ ❑ Part A ❑ Part B ❑ Part D

Email_____ Home Phone _____

DEPENDENT 2:

Last Name _____ First Name _____ M.I. ____ Gender ❑ Female ❑ Male

Date of Birth *(mm/dd/yy)*_____ Social Security Number _____

Is this dependent enrolled in Medicare? ❑ Yes ❑ No If "Yes", Effective Date ____/____/____ ❑ Part A ❑ Part B ❑ Part D

Email_____ Home Phone _____

DEPENDENT 3:

Last Name _____ First Name _____ M.I. ____ Gender ❑ Female ❑ Male

Date of Birth *(mm/dd/yy)*_____ Social Security Number _____

Is this dependent enrolled in Medicare? ❑ Yes ❑ No If "Yes", Effective Date ____/____/____ ❑ Part A ❑ Part B ❑ Part D

Email_____ Home Phone _____

DEPENDENT 4:

Last Name _____ First Name _____ M.I. ____ Gender ❑ Female ❑ Male

Date of Birth *(mm/dd/yy)*_____ Social Security Number _____

Is this dependent enrolled in Medicare? ❑ Yes ❑ No If "Yes", Effective Date ____/____/____ ❑ Part A ❑ Part B ❑ Part D

Email_____ Home Phone _____

If you have additional dependents, please provide their information on a separate sheet of paper.

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4. BROKER INFORMATION *(if applicable; if not, please leave blank)*

BROKER

Last Name _____ First Name _____

Broker Identification Number _____ E-Mail _____

Broker Agency _____

Phone _____

5. ACKNOWLEDGEMENT *(Read carefully before signing)*

I, the Primary Proposed Insured (or Spouse signing below), by my signature set forth thereafter, agree to the following:
(a) All statements and answers in this application are complete and true to the best of my knowledge and belief.
(b) Insurance will take effect only if a certificate is issued based on this application and the first premium is paid in full.
(c) No agent has the authority to waive any answer or otherwise modify this application or to bind the Company in any way by making any promise or representation which is not set out in writing in this application.

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.

_____
Signature

_____
Print Name

_____
Date

_____
Responsible Party (CHILD-ONLY PLAN)

Preferred method of Communication

❒ Mail ❒ Email