New York
Individual Enrollment Application

IMPORTANT: If you are a new applicant, a separate premium payment is required to be submitted with each application. If you are a current Individual policyholder with Empire BlueCross BlueShield, premium payment is required before the requested effective date. Please complete the Payment Method for Individual Applications Form and send it with your completed enrollment application. If premium is not provided as described above we will not process your application. If you have any questions while completing this application, please contact your insurance agent/broker directly. If you have not worked with an insurance agent/broker, please call 1 (877) 206-0915. If you have questions about a previously submitted application, please call 1 (855) 330-1104.

Please complete in blue or black ink only.

Section A – Coverage Information

Application Type (select one):

☐ New Coverage ☐ Change policy coverage Policy No._____ ☐ Add dependent(s) to current coverage Policy No._____

Open Enrollment

During the annual Open Enrollment period, you may apply for coverage, or members can change plans. The earliest Effective Date for the Initial Open Enrollment is January 1, 2014. For applications received after December 15, 2013, the Effective Date for the initial Open Enrollment period is the first day of the following month if receipt of application and premium is between the 1st and 15th of the month. If receipt of application and premium is after the 15th of the month, your Effective Date will be the first day of the month following plus one additional month (example: application with premium receipt is January 20th, your effective date is March 1st).

Applications must be received during the Open Enrollment period. Outside the Open Enrollment period referenced above, the applicant may still enroll if he/she has a qualifying event as defined below. Notice of a qualifying event must be received by Empire BlueCross BlueShield within 60 days of the qualifying event.

Qualifying Events

Please check the qualifying event:

☐ Involuntary loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay premium;

☐ Loss of Minimum Essential Coverage due to dissolution of marriage;

☐ Marriage;

☐ Adoption or placement for adoption or appointment of guardianship;

☐ Birth.

Please provide the date of the qualifying event: _____

If you are applying due to a qualifying event and your application is approved, your effective date is as follows:

- In the case of birth, adoption or placement for adoption or appointment of guardianship, coverage is effective on the date of birth, adoption, or placement for adoption or appointment of guardianship; or
- In the case of marriage, or loss of Minimum Essential Coverage, coverage is effective on the first day of the month following receipt of your application.

Section B – Applicant Information

Last Name	First Name	MI	Social Security Number*

Home Address (street and P.O. Box if applicable)			

City	State	ZIP	County

Billing Address (street and P.O. Box if different from above)		

City	State	ZIP

Marital Status ☐ Single ☐ Married	Sex ☐ M ☐ F	Date of Birth / /

Primary Phone Number ( )	Secondary Phone Number ( )	E-mail*

**This information is used for internal purposes only and will not be disclosed unless you select the health savings account option in this Application.*

Section C – Spouse or Domestic Partner to be Covered Information

Last Name	First Name	MI	Relationship ☐ Spouse ☐ Domestic Partner

Social Security Number*	Sex ☐ M ☐ F	Date of Birth / /

**This information is used for internal purposes only and will not be disclosed unless you select the health savings account option in this Application.*

NOTE: Spouses must have entered into a marriage legally recognized in the jurisdiction in which it is performed.

Section D – Child Dependents to be Covered Information (All fields required. Attach a separate sheet if necessary).

An eligible dependent is the natural or adopted child or stepchild of you or your spouse, and any proposed adoptive child who is dependent on you pending finalization of the adoption, to age 26. Over-age disabled dependent children may also qualify. See your policy for details. Dependents are also eligible for coverage from ages 26 through 29 without regard to financial dependence, if the dependent is: unmarried, not insured by or eligible for coverage under an employer sponsored health benefit plan covering them as an employee or member, whether insured or self-insured, AND lives, works or resides in New York State. In order to extend coverage for young adults through age 29, see options under the Medical Coverage Section. Coverage of each child lasts until the end of the month in which the child no longer meets eligibility conditions.

Last Name	First Name	MI	Sex	Date of Birth mm/dd/yyyy	Social Security Number*	Relationship to Applicant
			M F ☐ ☐	/ /		☐ Child ☐ Other:_____
			M F ☐ ☐	/ /		☐ Child ☐ Other:_____
			M F ☐ ☐	/ /		☐ Child ☐ Other:_____
			M F ☐ ☐	/ /		☐ Child ☐ Other:_____
			M F ☐ ☐	/ /		☐ Child ☐ Other:_____

**This information is used for internal purposes only and will not be disclosed unless you select the health savings account option in this Application.*

Do you have a child age 26 or over who is mentally retarded, physically handicapped or developmentally disabled for whom coverage is being requested under this contract? ☐ Yes ☐ No

If YES, a separate enrollment form (HAC 506) must be submitted to determine eligibility.

☐ **Please send me a form (HAC 506).**

Are all applicants listed on this application residents of the state in which you are applying for coverage? ☐ Yes ☐ No

If **NO**, who? _____

Preferred written language? (Optional)

☐ English (ENG) ☐ Spanish (SPN)

Preferred spoken language? (Optional)

☐ English (ENG) ☐ Spanish (SPN)

Section E – Medical Coverage

Plan Name and Deductible/Coinsurance Options

Select ONE Plan.

Total Family Deductible is two (2) times the amount shown.

Empire BlueCross BlueShield is licensed to operate in a 28 county service area in New York State. Applicants must live or reside in one of these counties to enroll: Albany, Clinton, Bronx, Columbia, Delaware, Dutchess, Essex, Fulton, Greene, Kings, Montgomery, Nassau, New York, Orange, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington, Westchester. You must be able to demonstrate, upon request, that you meet this requirement. PO Boxes are not accepted as a valid address.

Empire Core Guided Access:

- ☐ **Empire Core Guided Access –cabs $4,000/40% (0SU9)**
- ☐ **with Child Dental –cdbs (0SUE)**
- ☐ **with Dependent Age 29 –ccra (0SUK)**
- ☐ **with Child Dental and Dependent Age 29 –cdgc (0SUQ)**
- ☐ **with SNF –ccge(0YME)**
- ☐ **with Child Dental and SNF –cdkd (0YMK)**
- ☐ **with Dependent Age 29 and SNF –ccyd (0YMH)**
- ☐ **with Child Dental, Dependent age 29 and SNF –cdje (0YMN)**

- ☐ **Empire Core Guided Access –caat $5,800/20% (0SU7)**
- ☐ **with Child Dental –cdat (0SUC)**
- ☐ **with Dependent Age 29 –cbra (0SUH)**
- ☐ **with Child Dental and Dependent Age 29 –cdgb (0SUN)**
- ☐ **with SNF –ccgd (0YMD)**
- ☐ **with Child Dental and SNF –cdkc (0YMJ)**
- ☐ **with Dependent Age 29 and SNF –ccyc (0YMG)**
- ☐ **with Child Dental, Dependent Age 29 and SNF –cdjd (0YMM)**

Empire Essential Guided Access:

- ☐ **Empire Essential Guided Access –cbjw $2250/25% (0SV0)**
- ☐ **with Child Dental –cdce (0SVE)**
- ☐ **with Dependent Age 29 –ceae (0SVV)**
- ☐ **with Child Dental and Dependent Age 29 –cdec (0SW9)**
- ☐ **with SNF –cesd (0YMP)**
- ☐ **with Child Dental and SNF –cdka (0YMV)**
- ☐ **with Dependent Age 29 and SNF –catd (0YMT)**
- ☐ **with Child Dental, Dependent Age 29 and SNF –cdkb (0YMY)**

- ☐ **Empire Essential Guided Access for Child Only –cade $2000 (0TMK)**
- ☐ **with Child Dental –cdbb (0TMQ)**
- ☐ **with SNF –ccub (0YMR)**
- ☐ **with Child Dental and SNF –cdub (0YMX)**

Empire Preferred Guided Access

- ☐ **Empire Preferred Guided Access –cecb $1,000/10% (0SWQ)**
- ☐ **with Child Dental –cdgd (0SWT)**
- ☐ **with Dependent Age 29 –ceea (0SWW)**
- ☐ **with Child Dental and Dependent Age 29 –ccvd (0SWZ)**
- ☐ **with SNF –ceud (0YN0)**
- ☐ **with Child Dental and SNF –cdve (0YN3)**
- ☐ **with Dependent Age 29 and SNF –cetd (0YN2)**
- ☐ **with Child Dental, Dependent Age 29 and SNF –cdwa (0YN5)**

- ☐ **Empire Preferred Guided Access for Child Only –cadd $600 (0TMY)**
- ☐ **with Child Dental –cdha (0TN0)**
- ☐ **with SNF –ccxb (0YN1)**
- ☐ **with Child Dental and SNF –cdxb (0YN4)**

Empire Premier Guided Access

- ☐ **Empire Premier Guided Access –cazd $200/5% (0SX6)**
- ☐ **with Child Dental –cdwc (0SX9)**
- ☐ **with Dependent Age 29 –cayd (0SXC)**
- ☐ **with Child Dental and Dependent Age 29 –cdwd (0SXF)**
- ☐ **with SNF –caxd (0YN6)**
- ☐ **with Child Dental and SNF –cdva (0YNC)**
- ☐ **with Dependent Age 29 and SNF –cbxd (0YNA)**
- ☐ **with Child Dental, Dependent Age 29 and SNF –cdvb (0YNG)**

- ☐ **Empire Premier Guided Access for Child Only –caed $0 (0TN4)**
- ☐ **with Child Dental –cdja (0TN6)**
- ☐ **with SNF –cczb (0YN8)**
- ☐ **with Child Dental and SNF –cdzb (0YNE)**

Empire Premier Guided Access with Out-of-Network

The following Out-of-Network Plans are only available to current Empire Direct Pay HMO/POS members.

- ☐ **Empire Premier Guided Access with Out-of-Network –ccze $200/5% (0SXL)**
- ☐ **with Out-of-Network and Child Dental –cdaa (0SXM)**
- ☐ **with Out-of-Network and Dependent Age 29 –cczc (0SXN)**
- ☐ **with Out-of-Network, Child Dental, and Dependent Age 29 –cdzc (0SXP)**
- ☐ **with Out-of-Network and SNF –ccxd (0YN7)**
- ☐ **with Out-of-Network, Child Dental, Dependent age 29 and SNF –cdrd (0YND)**
- ☐ **with Out-of-Network, Dependent Age 29 and SNF –ccod (0YNB)**
- ☐ **with Out-of-Network, Child Dental, Dependent Age 29 and SNF –cdzd (0YNH)**

- ☐ **Premier Guided Access for Child Only with Out-of-Network –cajd $0 (0TN9)**
- ☐ **with Out-of-Network and Child Dental –cdyc (0TNA)**
- ☐ **with Out-of-Network and SNF –ceec (0YN9)**
- ☐ **with Out-of-Network, Child Dental and SNF –cdec (0YNF)**

HSA Plans

- ☐ **Empire Essential Guided Access with HSA –cdib $2,450/10% (0SV5)**
- ☐ **with HSA and Child Dental –cdmb (0SVK)**
- ☐ **with HSA and Dependent Age 29 –cefa (0SW0)**
- ☐ **with HSA, Child Dental and Dependent Age 29 –cdwe (0SWE)**
- ☐ **with HSA and SNF –casd (0YMQ)**
- ☐ **with HSA, Child Dental and SNF –cdrc (0YMW)**
- ☐ **with HSA, Dependent Age 29 and SNF –ccsd (0YMU)**
- ☐ **with HSA, Child Dental, Dependent Age 29 and SNF –cdra (0YMZ)**

- ☐ **Empire Core Guided Access for Child Only with HSA –cadc $3,000/50% (0SXT)**
- ☐ **with HSA and Child Dental –cdea (0TMF)**
- ☐ **with HSA and SNF –casb (0YMF)**
- ☐ **with HSA, Child Dental and SNF –cdsb (0YML)**

☐ **YES**, I would like to establish a health savings account in conjunction with the HSA-compatible health plan I selected. Please forward my information to Empire BlueCross BlueShield's banking partner. (Please fill in your social security number in Section B.)

☐ **NO, I DO NOT** want to establish a health savings account in conjunction with the HSA-compatible health plan I selected above. Please **DO NOT** forward my information to Empire BlueCross BlueShield's banking partner.

Please choose a Primary Care Physician for each family member from the Provider Directory, which can be found at www.empireblue.com, or by calling 1 888-266-3016. If you do not choose a PCP, then one will be selected for you.

Applicant	**Primary Care Physician (PCP)**	**PCP ID**	**Current Patient**	**PMG/IPA ID***
Primary Applicant			☐ Yes ☐ No	
Spouse/ Domestic Partner			☐ Yes ☐ No	
Dependent Name:			☐ Yes ☐ No	
Dependent Name:			☐ Yes ☐ No	
Dependent Name:			☐ Yes ☐ No	
Dependent Name:			☐ Yes ☐ No	
Dependent Name:			☐ Yes ☐ No	

**PMG = Participating Medical Group, IPA = Independent Practice Association*

☐ Please check box if any additional sheets of paper have been completed for this section. If so, please attach and return the additional sheets with this application.

Section F – Dental Coverage

☐ **Yes, I wish to add dental coverage (at an extra cost per individual)**

Select ONE plan below:

☐ Empire BlueCross BlueShield Dental Pediatric
☐ Empire BlueCross BlueShield Dental Pediatric Enhanced
☐ Empire BlueCross BlueShield Dental Adult
☐ Empire BlueCross BlueShield Dental Adult Enhanced
☐ Empire BlueCross BlueShield Dental Family
☐ Empire BlueCross BlueShield Dental Family Enhanced

Select who you are enrolling (applies to individuals listed on this application only):

☐ Applicant only
☐ Applicant & Spouse or Domestic Partner only
☐ Applicant & all dependent children listed
☐ Applicant, Spouse or Domestic Partner, and all dependent children listed
☐ All dependent children listed

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**, we will provide you coverage of the pediatric dental essential health benefit.

Section G – Other Health Coverage

Are you or anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ No

If **YES**, who? _____

Are you or anyone applying for coverage currently receiving Social Security Disability, Medicare, Medicaid or other government program benefits, or unable to work due to disability or receiving Workers' Compensation benefits? ☐ Yes ☐ No

If **YES**, who and reason:

_____

_____

Start date of benefits/coverage: ____/____/_____ End date of benefits/coverage: ____/____/_____

Do you, or anyone applying for coverage, currently have health care coverage? ☐ Yes ☐ No

If YES, please provide the following:

Name(s) of covered persons. If the whole family, simply write ALL in space below.	Identification Number(s)
Name and phone number of prior carrier(s)	
Type of coverage ☐ Group ☐ Individual	Effective Date of Coverage

Will you be cancelling this coverage if approved for Empire BlueCross BlueShield coverage? ☐ Yes ☐ No

If **YES**, what is the cancellation date? _____

Section H – Significant Terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application.

- I understand that although Empire BlueCross BlueShield requires payment with my application, sending my initial premium with this application, and the receipt of my payment by Empire BlueCross BlueShield, does not mean that coverage has been approved. I may not assign any payment under my Empire BlueCross BlueShield plan. I am applying for the coverage selected on this application. I understand that, to the extent permitted by law, Empire BlueCross BlueShield reserves the right to accept or decline this application, and that no right whatsoever is created by this application. I understand that if my application is denied, my bank account or credit card will not be charged.
- I am responsible to timely notify Empire BlueCross BlueShield of any change that would make me or any dependent ineligible for coverage.
- I understand Empire BlueCross BlueShield may convert my payment by check to an electronic Automated Clearinghouse (ACH) debit transaction and that my original check will be destroyed. The debit transaction will appear on my bank statement although my check will not be presented to my financial institution or returned to me. This ACH debit transaction will not enroll me in any Empire BlueCross BlueShield automatic debit process and will only occur each time I send a check to Empire BlueCross BlueShield. Any resubmissions due to insufficient funds may also occur electronically. I understand that all checking transactions will remain secure, and my payment by check constitutes acceptance of these terms.
- By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Empire BlueCross BlueShield and myself.
- I understand I am applying for individual health coverage which is not part of any employer-sponsored plan. I certify that neither I nor any dependent is receiving any form of reimbursement or compensation for this coverage from any employer. I understand that I am responsible for 100% of the premium payment and I am also responsible to ensure that premiums are paid.
- ☐ By checking this box, I authorize and expressly consent that Empire BlueCross BlueShield and its affiliated companies may send and deliver to me any communication that is not required to be provided to me by United States mail, including but not limited to legally required Plan Notices, policies, agreements, evidence of coverage booklets and underwriting, enrollment and billing and explanation of benefits statements, electronically, either by e-mail or via the Internet. Examples of documents that will not be sent by electronic means and will continue to be sent by U.S. Mail include notices of cancellation, notices of grace period, notices that will terminate your coverage, and notices regarding a denial of coverage. I understand that I can revoke this authorization or request paper copies at any time by contacting Empire BlueCross BlueShield customer service or online at www.empireblue.com.
- All statements and answers in this application are true, and are representations made to induce the issuance of coverage. Any, act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact found in this application may result in denial of benefits, rescission, or cancellation of my coverage(s).

I give this authorization for and on behalf of any eligible dependents and myself if covered by Empire BlueCross BlueShield. I am acting as their agent and representative.

This application shall be altered solely by the applicant or with his or her written consent.

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. I have read, understand and agree to all the provisions set forth.

SIGN HERE		
	Signature of Applicant* or Legal Representative X	Date
	Signature of Spouse or Domestic Partner or Dependent Child(ren) age 18 or over (if to be covered) or Legal Representative X	Date
	Signature of Dependent Child(ren) age 18 or over (if to be covered) X	Date

** (or Custodial Parent's or Guardian's signature if applicant is under age 18)*

Section I – Agent/Broker Certification

To be completed by your Empire BlueCross BlueShield-appointed agent/broker:

Did you see the proposed subscriber and spouse/domestic partner, if applying at the time this application was executed? ☐ Yes ☐ No

If **NO**, please explain: _____

I certify to the best of my knowledge and belief, the responses herein are accurate.

Agent/Broker Signature **X**			Date
Agent/Broker Name (please print)		Agent/Broker Street Address/Suite No./Personal Mail Box (PMB) No.	
Agent/Broker ID/TIN	Agency ID/Parent TIN	City State ZIP	
Agent/Broker Phone No.	Agent/Broker Fax No.	Agent/Broker E-mail	
GA (if applicable)		GA code (if applicable)	

Authorization for Use of Protected Health Information

By signing below: I authorize Empire BlueCross BlueShield, or an agent/broker, subsidiary or affiliate that has a business associate contract with Empire BlueCross BlueShield, to obtain any medical records or other health history information concerning me and any family member listed on my Application from any physicians, hospitals, pharmacies, other health care providers, pharmacy benefits managers, health benefits plans, health insurers, medical or pharmacy benefit administrators, Consumer Reporting Agencies, MIB, Inc., formerly Medical Information Bureau (MIB), and/or insurance support organizations.

This authorization is subject to revocation at any time by written notice to Empire BlueCross BlueShield except to the extent that Empire BlueCross BlueShield has already taken action in reliance on this authorization. If I revoke this authorization after I initially apply for coverage, I understand that I/we will not be considered for coverage. If I revoke this authorization after I ask to upgrade my coverage or add a family member, I understand that the change will not be made. I understand that if my and/or my family's information is to be received by individuals or organizations that are not health care providers, health care clearinghouses or health plans governed by federal privacy regulations, my/our information might be re-disclosed by any of those recipients and will not be protected by federal privacy regulations. A copy of this authorization is available to me, or to my authorized representative, upon request and will serve as the original.

Unless previously revoked, this authorization is valid for 24 months from the date of signature.

SIGN HERE

Printed name of Applicant/Member **X**	Signature of Applicant/Member or his/her Legal Representative **X**	Date
Printed name of Spouse or Domestic Partner or Dependent Child* age 18 or over listed on Application **X**	Signature of Spouse or Domestic Partner or Dependent Child* or his/her Legal Representative **X**	Date
Printed name of Dependent Child* age 18 or over listed on Application **X**	Signature of Dependent Child* or his/her Legal Representative **X**	Date

**If listed on your application or change form, your spouse/domestic partner and each dependent child age 18 or over must sign above.*
If a legal representative signs on behalf of the applicant or spouse or domestic partner, a copy of the legal representative's authority must be attached to the application.
A photocopy of this form will be as valid as the original. You or an authorized representative have the right to receive a copy of this Authorization upon request.

Please mail this application to the following address:

Empire

P.O. Box 659806

San Antonio, TX 78265-9106

Or

Fax to: 1 (800) 848-2512

Services provided by Empire HealthChoice HMO, Inc., licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

Payment Methods for Individual Applications – New York

Applicant / Member Name:	Primary Applicant's SSN:

Premium Payment is required. Please choose from Option 1 or 2

Please Note: All Payments will be debited as soon as the date of enrollment.

☐ **OPTION 1** – If you choose the following option for **INITIAL and FUTURE MONTHLY** payments, you are **NOT** required to make a selection from Option 2 for your initial payment.

☐ Monthly Automatic Premium Payment (complete Section A)

☐ **OPTION 2 –** If you did not select **OPTION 1**, please choose from the options below for your **INITIAL** premium payment. **If you choose one of these options, you will receive a bill every month thereafter which you will be responsible for payment.**

☐ Paper Check*
☐ Electronic Check (complete Section B)
☐ Credit / Debit Card (complete Section C)

A. Monthly Automatic Premium Payment – By providing your bank information, you authorize us to electronically debit your bank account. I understand this authorization will apply to all products selected. Subsequent premium amounts will be debited on the day you request below:

☐ Checking Account

☐ Savings Account
(You may need to contact your financial institution for routing and account number information.)

Requested Debit Day: _____ (1st to 6th of each month). If no date is requested, your premiums will be debited on the first of each month.

Provide your Routing and Account Numbers here:

9-Digit Bank Routing Number	Bank Account Number

As a convenience to me, I request and authorize Empire Blue Cross and Blue Shield to pay and charge to my account checks drawn on that account by and made payable to the order of Empire Blue Cross and Blue Shield, provided there are sufficient collected funds in said account to pay the same upon presentation. I understand that the initial payment amount may vary as a result of change(s) during eligibility review, and/or subsequent payment amount may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, moving my residence, changing coverage and/or changes made by Empire Blue Cross and Blue Shield of which I am notified pursuant to my plan/policy. I agree that Empire Blue Cross and Blue Shield's rights with respect to each such debit shall be the same as if it were a check signed personally by me. I authorize Empire Blue Cross and Blue Shield to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Empire Blue Cross and Blue Shield premiums. This authority is to remain in effect until revoked by me by providing Empire Blue Cross and Blue Shield a 30-day written notice. I agree that Empire Blue Cross and Blue Shield shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, Empire Blue Cross and Blue Shield shall be under no liability whatsoever even though such dishonor results in forfeiture of coverage. **NOTE:** I understand that should Empire Blue Cross and Blue Shield's withdrawal not be honored by my bank, I will automatically be removed from Monthly Automatic Premium Payment and will be billed by mail. **I will incur a service charge for any withdrawal not honored.**

Authorized Signature (as it appears in the financial institution's records)	Account Holder Name (Please PRINT)	Date
X		

B. Electronic Check – In lieu of sending a Paper Check, we can submit this same information electronically. We will need you to complete the information below. We require an exact amount to be debited.

Account Holder Name (Please PRINT)	Bank Routing Number	Account Number	Amount
			$

C. Credit / Debit Card - As a convenience to me, I request and authorize Empire Blue Cross and Blue Shield to charge my card for a one time initial debit upon approval. I understand this authorization will apply to all products selected. I understand that the initial payment amount may vary as a result of change(s) during eligibility review and/or subsequent payment amounts may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, moving my residence changing coverage, and/or changes made by Empire Blue Cross and Blue Shield of which I am notified pursuant to my plan/policy. I agree that Empire Blue Cross and Blue Shield shall be fully protected in honoring any such card payments. I further agree that if any such card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, Empire Blue Cross and Blue Shield shall be under no liability whatsoever, including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of coverage. **Empire Blue Cross and Blue Shield accepts Visa and MasterCard.**

Card Number:

Expiration Date:

Billing address for this Credit / Debit Card:

City:

Zip Code:

Authorized Signature (as it appears on the credit card)	Cardholder Name (as it appears on the credit card – Please Print)	Date
X		

* When you provide a check as payment, you authorize Empire Blue Cross and Blue Shield either to use information from your check to make a one-time electronic funds transfer from your account or to process the payment as a check transaction. When Empire Blue Cross and Blue Shield uses this information from your check to make an electronic funds transfer, funds will be withdrawn from your account as soon as the date of coverage approval and you will not receive your check back from your financial institution.

Services provided by Empire HealthChoice HMO, Inc. and/or Empire HealthChoice Assurance, Inc., licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.