



Enrollment Application/Change Form

500 Patroon Creek Blvd.
Albany, NY 12206-1057
(518) 641-5000 or 1-800-993-7299

EMPLOYER USE ONLY

Date Hired (MM/DD/YY) _____ Full-time Part-time (≤20 hours/week)
 Date coverage is effective _____ Active Retiree COBRA
 Date of status change _____ Employer Name _____
 Part- to full-time Union to non-union Other _____
 Group/Subgroup #: _____ Class #: _____
 Chamber Assoc: _____ **Grp Admin Initials (required)** _____

A. EXPLANATION Check all that apply

New Hire Open Enrollment Loss of Coverage Marriage Birth Change in Student Status Name/Address Change Court Order
 COBRA - Reason: Left Employ/Retirement Divorce/Legal Separation Death of Spouse Dependent Reached Max Age Loss of Student Status
 Termination - Reason: Employment Terminated Remove Dependents Only Deceased Other _____

B. COVERAGE INFORMATION

Product Type: HMO EPO PPO HDPPPO HNY FoxFirst
 PCP Copay Amt: \$ _____ Specialist Copay Amt: \$ _____ % Coins: _____ Deduct. Amt: \$ _____ **Drug Coverage** **Dental Coverage**

C. SUBSCRIBER INFO

1. Last Name _____ First Name _____ M.I. _____ 4. Telephone: Home _____ Work _____
 2. Street Address _____ Apt. # _____ 5. E-mail Address _____
 3. City _____ State _____ ZIP _____ 6. Employer Name _____

D. MEMBER INFO Name (list subscriber first)

For HMOs only, you and each dependent MUST select a Primary Care Physician (PCP). Females may also choose one OB/GYN. Also indicate if a member is a current patient and get the Physician # and Office Location from the provider directory or at www.cdphp.com. For all other products, include copy of your HIPAA certificate. If you have Medicare Parts A and B, include your Medicare card.

7a. Last _____ First _____ M.I. _____ SSN (Required) _____ Date of Birth _____ Add or Delete

Sex: M F Disabled End-Stage Renal Disease

Medicare number: _____ Part A effective date: _____ Part B effective date: _____

Previous coverage: Yes Previous carrier: _____ Effective from: _____ To: _____

HMO only - Physician (PCP) Last _____ First _____ M.I. _____ Office location _____ Phys # _____ Current Patient?

HMO only - OB/GYN Last _____ First _____ M.I. _____ Office location _____ Phys # _____ Current Patient?

7b. Last _____ First _____ M.I. _____ SSN (Required) _____ Date of Birth _____ Add or Delete

Rel: Spouse Other Sex: M F Disabled End-Stage Renal Disease

Medicare number: _____ Part A effective date: _____ Part B effective date: _____

Previous coverage: Yes Previous carrier: _____ Effective from: _____ To: _____

HMO only - Physician (PCP) Last _____ First _____ M.I. _____ Office location _____ Phys # _____ Current Patient?

HMO only - OB/GYN Last _____ First _____ M.I. _____ Office location _____ Phys # _____ Current Patient?

D. MEMBER INFO *Cont'd*

For **HMOs only**, you and each dependent **MUST** select a Primary Care Physician (PCP). Females may also choose one OB/GYN. Also indicate if a member is a current patient and get the Physician # and Office Location from the provider directory or at www.cdphp.com. For all other products, include copy of your HIPAA certificate. If you have Medicare Parts A and B, include your Medicare card.

7c. Last _____ First _____ M.I. _____ SSN (Required) _____ Date of Birth _____ Add or Delete

Rel: Son Daughter Full-time student? Disabled End-Stage Renal Disease

Medicare number: _____ Part A effective date: _____ Part B effective date: _____

School name (if student) _____ Expected date of graduation _____ School address (City, State, ZIP) _____

Previous coverage: Yes Previous carrier: _____ Effective from: _____ To: _____

HMO only - Physician (PCP) Last _____ First _____ M.I. _____ Office location _____ Phys # _____ Current Patient?

HMO only - OB/GYN Last _____ First _____ M.I. _____ Office location _____ Phys # _____ Current Patient?

7d. Last _____ First _____ M.I. _____ SSN (Required) _____ Date of Birth _____ Add or Delete

Rel: Son Daughter Full-time student? Disabled End-Stage Renal Disease

Medicare number: _____ Part A effective date: _____ Part B effective date: _____

School name (if student) _____ Expected date of graduation _____ School address (City, State, ZIP) _____

Previous coverage: Yes Previous carrier: _____ Effective from: _____ To: _____

HMO only - Physician (PCP) Last _____ First _____ M.I. _____ Office location _____ Phys # _____ Current Patient?

HMO only - OB/GYN Last _____ First _____ M.I. _____ Office location _____ Phys # _____ Current Patient?

7e. Last _____ First _____ M.I. _____ SSN (Required) _____ Date of Birth _____ Add or Delete

Rel: Son Daughter Full-time student? Disabled End-Stage Renal Disease

Medicare number: _____ Part A effective date: _____ Part B effective date: _____

School name (if student) _____ Expected date of graduation _____ School address (City, State, ZIP) _____

Previous coverage: Yes Previous carrier: _____ Effective from: _____ To: _____

HMO only - Physician (PCP) Last _____ First _____ M.I. _____ Office location _____ Phys # _____ Current Patient?

HMO only - OB/GYN Last _____ First _____ M.I. _____ Office location _____ Phys # _____ Current Patient?

E. OTHER INSURANCE

Do you, your spouse, or any of your dependents have any other medical insurance that will be maintained in addition to CDPHP? Yes: If yes, complete below. No

8. Policyholder name _____ Policy # _____ Insurance carrier _____ Employer name _____

Date of birth: _____ Address: _____

Effective date: _____ Coverage type: Hospital Medical Drug Dental Vision

Covered Individuals - Check all that apply Self Spouse Dependents

Note: Make sure you sign and date the application on the next page.

F. SIGNATURE: AGREEMENT: I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge and that I have read the important information on the last page of this form.

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 \$5,000 and the stated value of the claim for each such violation.

9. Applicant's Signature: _____

10. Date: _____

IMPORTANT INFORMATION

Failure to complete any sections will result in a processing delay of your application, member ID cards and, claims payment. Failure by your employer to complete the employer section will also result in a delay.

If you should have any questions about this Enrollment Application/Change Form, please call the CDPHP® marketing department at (518) 641-5000 or 1-800-993-7299. Thank you for choosing CDPHP for your health care coverage.

Your signature on this application hereby affirms the following:

On behalf of myself and any dependents listed, I hereby apply for coverage under the Master Group Contract issued to my employer by Capital District Physicians' Health Plan, Inc. and/or CDPHP Universal Benefits,® Inc. (CDPHP UBI).

I understand that the benefits for which I (we) will be eligible are in accordance with those described in the Master Group Contract and any attached riders. I further understand that for HMO benefits provided by Capital District Physicians' Health Plan, Inc., except for emergencies, covered services must be obtained through a participating physician (unless otherwise noted in rider) or in a participating hospital (unless otherwise noted in rider) when admitted or referred by a participating physician (unless otherwise noted in rider), and also that certain services may require a copayment (unless otherwise noted in rider) by me (or my dependents) directly to the provider of such services.

I hereby permit my employer to deduct the necessary Health Services Fees, if any, from my wages or salary, with the understanding that the employer acts as my agent in all dealings with CDPHP, and that all acts performed by the employer and all notices given to the employer in such dealings are binding upon me, as not prohibited by statute or regulation.

I understand that unresolved grievances are subject to the procedure specified in the Master Group Contract.

Note: CDPHP UBI coverage may have a pre-existing condition clause. Please consult your benefit materials or check with your personnel office for more specific information.

CDPHP COMPANIES

Capital District Physicians' Health Plan, Inc.
CDPHP Universal Benefits,® Inc.