

TRANSACTION FORM FOR GROUP ACCOUNTS

I. SUBSCRIBER INFORMATION

Last Name		First Name		M.I.	Sex	Social Security Number	
Street Address		Apt.	City			State	ZIP Code
Were you ever a member of EmblemHealth? ☐ NO ☐ YES If YES, member ID _____		Marital Status: ☐ Single ☐ Married ☐ Domestic Partner		Birth Date: Mo. Day Yr. Home Tel. #: _____ Work Tel. #: _____ Cell Tel. #: _____		Email Address: _____ ☐ "GO PAPERLESS" and save trees (see back of form)*	
Applicant's hours worked per week: ☐ at least 30 hours ☐ less than 30 hours ☐ COBRA		Type of Coverage: ☐ Individual ☐ Family ☐ Employee & Spouse/DP ☐ Employee & Child		Note: If electing Young Adult Coverage, please submit a completed Young Adult Election Form.			
Primary Care Physician Name: (Not required for EPO/PPD members) _____						ID Number: _____	
OB/GYN Selection Name: (Optional) _____						ID Number: _____	
Are you covered by any other health insurance or Medicare? ☐ NO ☐ YES If YES, indicate: Insurance Co. Name: _____ Insurance Co. Telephone #: _____ Type of Coverage: _____ Policy #: _____ Effective Date: _____				Check One: ☐ New Enrollment ☐ Reinstatement ☐ Termination ☐ Change to Ind.		Status: ☐ Add Dependent ☐ Remove Dep. ☐ Address Change ☐ Name Change	
				Transfer: ☐ To Another Carrier ☐ EmblemHealth Group Change: From: _____ To: _____			

II. ENROLLMENT INFORMATION — IF YOU ARE ENROLLING YOUR SPOUSE/DP AND/OR CHILDREN, PLEASE LIST EACH ONE BELOW — SEE ELECTION OF COVERAGE FOR ELIGIBILITY

Note: A birth/marriage certificate or 1040 Form will be required for spouse/dependents with different last name.										
Last Name (if different)	First Name	Social Security Number	Sex	Relationship	Birth Date			✓ if Disabled ¹	Primary Care Physician Name/ID Number (Not required for EPO/PPD members)	OB/GYN Selection Name/ID Number (Optional)
DEPENDENT				☐ Spouse ☐ DP ☐ Child	Mo.	Day	Yr.			
Current Health Insurance Information: Carrier Name: _____ Coverage Begin Date: _____ Coverage End Date: _____										
DEPENDENT				☐ Child						
Current Health Insurance Information: Carrier Name: _____ Coverage Begin Date: _____ Coverage End Date: _____										
DEPENDENT				☐ Child						
Current Health Insurance Information: Carrier Name: _____ Coverage Begin Date: _____ Coverage End Date: _____										

¹For dependent adult children incapable of self-sustaining employment, please see Section A on the back side of this form to check the appropriate "Add Dependent" box, and follow the instruction for required documentation.

Your signature is required to process this form. Your signature attests that you have read the reverse side 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 material fact associated with such application commits a fraudulent insurance act. Such act is a crime, and will be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Applicant must sign here: _____ **Date:** _____

III. EMPLOYER INFORMATION — THIS SECTION TO BE COMPLETED BY EMPLOYER/CONTRACTOR GROUP

Name of Group:		Group Number:		☐ EmblemHealth ☐ GHI ☐ GHI HMO ☐ HIP Plan Name: _____		If you selected a small group metal plan, please check which type: ☐ Gold ☐ Silver ☐ Bronze	
Requested Effective Date: Medical: _____ Dental: _____		Hire Date:		Waiting Period:		Date Submitted:	
						Approved By: (Group Plan Administrator)	

Instructions to Benefit Administrators or Group Representatives: For groups with 50 employees or fewer, you MUST complete Section A on the reverse side of this form. Required documentation MUST be attached to this Transaction Form to be processed.

IMPORTANT INFORMATION

1. The subscriber must complete sections I and II. The group plan administrator must complete section III and if for a small group (50 employees or fewer), provide all necessary documentation.
2. All transactions are subject to EmblemHealth's retroactive enrollment period – members must be enrolled within 30 days (for small groups) or 90 days (for large groups) from the Qualifying Event/next billing date.
3. As part of New York State's "age 29" law, eligible young adults through age 29 may obtain coverage through a parent's group policy.
4. Failure to complete any part of this form (e.g., group number, reason for submission, certificate number, signature, etc.) will require EmblemHealth to return this transaction form to the employer group plan administrator and may delay the requested effective date of coverage.
5. Return the completed Transaction Form along with any required documentation to: Membership, PO Box 2820, New York, NY 10116-2820.

Get more information at www.emblemhealth.com.

SECTION A

(To be completed by Benefits Administrator)

ACTION Check (✓)One	Qualifying Event	Documentation Required
☐ Add Subscriber	New Hire or Change in Plan	For eligible employees who work at least 30 hours per week, provide a recent Copy of NYS45 showing this subscriber as an employee or provide copy of payroll documentation reflecting the date, employee's name and Social Security #, or the employee's current-year W4 form.
☐ Add Spouse	Marriage	If last name is different ☐ Marriage Certificate ☐ 1040 Form
☐ Add Dependent	Birth or Adoption	If last name is different ☐ Birth Certificate ☐ Formal Adoption Papers ☐ Court Approved Guardianship Papers
☐ Add Young Adult	Young Adult Coverage	Young Adult Election Form
☐ Add Dependent	Dependent Adult Child Incapable of Self-Sustaining Employment	Disability Status Request Form
☐ Add Spouse ☐ Add Dependent	Loss of Coverage	Certificate of Creditable Coverage
☐ Add Domestic Partner	Domestic Partnership	Declaration of Cohabitation & Financial Interdependence form

Note: No exceptions to our retroactive enrollment period will be allowed. Small group members must be enrolled within 30 days from the Qualifying Event/next billing date (or within 90 days for large group members).

*By electing "Go Paperless," you will receive claim statements and some other EmblemHealth letters by email instead of paper mail. You will be able to view your Explanation of Benefits (EOBs) under the Claims section of the EmblemHealth website. Your enrollment in the "Go Paperless" option will continue as long as your account remains active, or until you choose to discontinue this option.