



PO Box 80, Buffalo, NY 14240-0080

## **Enrollment Application/Change Form — SMALL**

Cubaculhar Clature Active Defined CODDA	e use blue or black ink, print one character per box.
Subscriber Status: Active Retired COBRA	Please indicate reason for COBRA:
Group # Subgroup # Class #	○ Left Employ / Retirement ○ Death of Spouse
	Divorce/Legal Separation     Dependent Reached Max Age
Employer Name	Closs of Student Status Other
	Effective Date (MMDDYY) COBRA Effective Date (MMDDYY)
Association/Chamber Name (if applicable)	
	Hire/Rehire Date (MMDDYY)  Retired Effective Date (MMDDYY)
Group Administrator Signature / Date	
<b>√</b>	
Subscriber Plan Section Please use blue or black ink, print one ch	aracter per box. Check applicable plan(s).
Plan Number: Please indicate copay: PCP \$	Specialist \$ Single or Family:
O POS O POS Plus O Dental O HMO HMO Plus	Please choose coverage type
PPO Traditional Vision EPO Aqua O	Other Opental S F
	○ Vision ○ S ○ F
A. Have you obtained stand-alone dental coverage that provides a pediatric dental esser     New York Health Benefit Exchange-certified stand-alone dental plan offered outside the stand-alone dental plan outside the stand-alone dental plan offered outside the stand-alone dental plan outside th	
B. If you answered "yes", please provide the name of the company issuing the stand-alo	<b>0</b> •
If you answered "no", we will provide coverage of the pediatric dental essential h	ealth benefit.
3—Reason for Enrollment/Change - Subscriber, please indicate the rea	son for this enrollment or change.
New Hire COBRA Primary Care F	Physician Remove Dependent Loss of Coverage
Open Enrollment Address/Phone Number Last Name	Retirement
Open Enrollment Address/Phone Number Last Name  Add Dependent Please indicate reason for adding dependent: Newb	orn Marriage Loss of Coverage
Add Dependent Please indicate reason for adding dependent:  Newb  4—Subscriber Information  Adopt	orn
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Add Dependent Please indicate reason for adding dependent:  Newb  4—Subscriber Information  Adopt  Please complete both sides of this application. The subscriber signal Subscriber's Last Name	orn Marriage Loss of Coverage ion Domestic Partner Change in Student Status ature is required in order to process the application.  Subscriber's First Name M.I.
Add Dependent Please indicate reason for adding dependent:  Newb  4—Subscriber Information  Adopt  Please complete both sides of this application. The subscriber signs	orn
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Add Dependent Please indicate reason for adding dependent:  Newb  4—Subscriber Information  Adopt  Please complete both sides of this application. The subscriber signal Subscriber's Last Name  Social Security Number  Date of Birth (MMDDYY)  Mailing Address  City  State  E-mail Address  Medicare Eligible Please indicate reason for Medicare eligibility:  Age 6	Orn

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5—Dependent Information continued			
Please provide all information for each per	son to be covered.		
Subscriber's Last Name		Subscriber's First Name	M.I.
Social Security Number	Date of Birth (MMDDYY)		
Dependent's Last Name		Dependent's First Name	M.I.
Social Security Number	Date of Birth (MMDDYY)	Gender: Female Male	
		Is your over-age dependent handicapped?	O No
E-mail Address			
Medicare Eligible Please indicate reason for Med	care eligibility:	Age 65+ Oisability End Stage Renal Disease	
Medicare Number (if applicable)	Part A Effective Date (MMI	DDYY) Part B Effective Date (MMDDYY) Part D Effective Date (MMD	DYY)
Is dependent a full-time student? Yes	O No If yes	s, please indicate college/university name:	_
College/University Name		Expected Graduation Date (MMI	DDYY)
Primary Care Physician's Last Name		Primary Care Physician's First Name	
Primary Care Physician Number: Are you a current patient,	r if not a current patient, have	you verified that the PCP will accept you as a new patient? Yes	O No
		Do you have additional group health insurance? O Yes	O No
If you answered "yes" to the question about stand-alo	। e dental coverage in secti	ion 2, please provide the name of the company issuing the covera	ge.
If you answered "no", we will provide coverage of t	ne pediatric dental esser	ntial health benefit.	
Dependent's Last Name		Dependent's First Name	M.I.
Dependent's Last Name		Dependent's First Name	M.I.
	Date of Birth (MMDDYY)	Dependent's First Name  Gender: Female Male	M.I.
	Date of Birth (MMDDYY)		M.I.
	Date of Birth (MMDDYY)	Gender: Female Male	
Social Security Number	Date of Birth (MMDDYY)	Gender: Female Male	
Social Security Number		Gender: Female Male	
Social Security Number  E-mail Address  Medicare Eligible Please indicate reason for Medicare	care eligibility:	Gender: Female Male Is your over-age dependent handicapped? Yes  Age 65+ Disability End Stage Renal Disease	O No
Social Security Number  E-mail Address  Medicare Eligible Please indicate reason for Medicare		Gender: Female Male Is your over-age dependent handicapped? Yes  Age 65+ Disability End Stage Renal Disease	O No
Social Security Number  E-mail Address  Medicare Eligible Please indicate reason for Med  Medicare Number (if applicable)	care eligibility:  Part A Effective Date (MMI	Gender: Female Male Is your over-age dependent handicapped? Yes  Age 65+ Disability End Stage Renal Disease	O No
Social Security Number  E-mail Address  Medicare Eligible Please indicate reason for Med  Medicare Number (if applicable)  Is dependent a full-time student?  Yes	care eligibility:  Part A Effective Date (MMI	Gender: Female Male  Is your over-age dependent handicapped? Yes  Age 65+ Disability End Stage Renal Disease  DDYY) Part B Effective Date (MMDDYY) Part D Effective Date (MMD  s, please indicate college/university name:	ODYY)
Social Security Number  E-mail Address  Medicare Eligible Please indicate reason for Med  Medicare Number (if applicable)  Is dependent a full-time student?  Yes	care eligibility:  Part A Effective Date (MMI	Gender: Female Male Is your over-age dependent handicapped? Yes  Age 65+ Disability End Stage Renal Disease  DDYY) Part B Effective Date (MMDDYY) Part D Effective Date (MMDDYY)	ODYY)
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Social Security Number  E-mail Address  Medicare Eligible Please indicate reason for Med  Medicare Number (if applicable)  Is dependent a full-time student?  Yes	care eligibility:  Part A Effective Date (MMI	Gender: Female Male  Is your over-age dependent handicapped? Yes  Age 65+ Disability End Stage Renal Disease  DDYY) Part B Effective Date (MMDDYY) Part D Effective Date (MMD  s, please indicate college/university name:	ODYY)
Social Security Number  E-mail Address  Medicare Eligible Please indicate reason for Med Medicare Number (if applicable)  Is dependent a full-time student?  College/University Name  Primary Care Physician's Last Name	care eligibility:  Part A Effective Date (MMI  No If yes	Gender: Female Male Is your over-age dependent handicapped? Yes  Age 65+ Disability End Stage Renal Disease  DDYY) Part B Effective Date (MMDDYY) Part D Effective Date (MMD  s, please indicate college/university name:  Expected Graduation Date (MMD  Primary Care Physician's First Name	ODYY)
Social Security Number  E-mail Address  Medicare Eligible Please indicate reason for Med Medicare Number (if applicable)  Is dependent a full-time student?  Yes  College/University Name	care eligibility:  Part A Effective Date (MMI  No If yes	Gender: Female Male Is your over-age dependent handicapped? Yes  Age 65+ Disability End Stage Renal Disease DDYY) Part B Effective Date (MMDDYY) Part D Effective Date (MMDDYY) s, please indicate college/university name:  Expected Graduation Date (MMDDY) Primary Care Physician's First Name e you verified that the PCP will accept you as a new patient? Yes	O No ODYY)
Social Security Number  E-mail Address  Medicare Eligible Please indicate reason for Med  Medicare Number (if applicable)  Is dependent a full-time student? Yes  College/University Name  Primary Care Physician's Last Name  Primary Care Physician Number: Are you a current patient,	care eligibility:  Part A Effective Date (MMI  No If yes	Gender: Female Male Is your over-age dependent handicapped? Yes  Age 65+ Disability End Stage Renal Disease  DDYY) Part B Effective Date (MMDDYY) Part D Effective Date (MMDDY)  s, please indicate college/university name:  Expected Graduation Date (MMDDY)  Primary Care Physician's First Name  e you verified that the PCP will accept you as a new patient? Yes  Do you have additional group health insurance? Yes	No No No No No No
Social Security Number  E-mail Address  Medicare Eligible Please indicate reason for Med  Medicare Number (if applicable)  Is dependent a full-time student? Yes  College/University Name  Primary Care Physician's Last Name  Primary Care Physician Number: Are you a current patient,	care eligibility:  Part A Effective Date (MMI  No If yes	Gender: Female Male Is your over-age dependent handicapped? Yes  Age 65+ Disability End Stage Renal Disease DDYY) Part B Effective Date (MMDDYY) Part D Effective Date (MMDDYY) s, please indicate college/university name:  Expected Graduation Date (MMDDY) Primary Care Physician's First Name e you verified that the PCP will accept you as a new patient? Yes	No No No No No No



Please provide all information for each pe	
Dependent's Last Name	Dependent's First Name M.I
Social Security Number	Date of Birth (MMDDYY) Gender: Female Male
	Is your over-age dependent handicapped? Yes
E-mail Address	
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Medicare Number (if applicable)	Part A Effective Date (MMDDYY) Part B Effective Date (MMDDYY) Part D Effective Date (MMDDYY)
s dependent a full-time student? Yes	No If yes, please indicate college/university name:
College/University Name	Expected Graduation Date (MMDDYY
Primary Care Physician's Last Name	Primary Care Physician's First Name
Primary Care Physician Number: Are you a current patient	t, or if not a current patient, have you verified that the PCP will accept you as a new patient? Yes
	Do you have additional group health insurance? Yes
f you answered "yes" to the question about stand-ak	one dental coverage in section 2, please provide the name of the company issuing the coverage.
f you answered "no", we will provide coverage of	f the pediatric dental essential health benefit.
<ul> <li>(WHCRA). For individuals receiving mastectomy-physician and the patient, for:</li> <li>All stages of reconstruction of the breast on Surgery and reconstruction of the other brea</li> <li>Prostheses; and;</li> <li>Treatment of physical complications of the master of the mas</li></ul>	ast to produce a symmetrical appearance;
If you would like more information on WHCRA beautiful to the control of the contr	enefits, call your Plan Administrator.
6—Disclosure / Signature	
Subscriber signature required.	
REQUESTED CONCERNING MEDICAL SERVICE	PITAL OR OTHER HEALTH CARE PROVIDER TO PROVIDE MY PLAN WITH ANY INFORM CES I OR MEMBERS OF MY FAMILY HAVE RECEIVED, WHICH THE PLAN DETERMINES GULATION OF THE PLAN. THIS INFORMATION WILL BE KEPT CONFIDENTIAL AND IS VA
FILES AN APPLICATION FOR INSURANC INFORMATION, OR CONCEALS FOR THE THERETO, COMMITS A FRAUDULENT IN	WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSO CE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE E PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATE ISURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO CIV SAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH