





# Enrollment Application/Change Form

CDPHP Universal Benefits, Inc.  
 Patroon Creek Corporate Center  
 1223 Washington Avenue • Albany, NY 12206-1057  
 (518) 641-5000 or 1-800-993-7299

EXPLANATION	Check all that apply	Explanation and Effective Date	EMPLOYER USE
	<input type="checkbox"/> New Enrollment <input type="checkbox"/> Name Change <input type="checkbox"/> Cobra Continuation <input type="checkbox"/> Add Dependent <input type="checkbox"/> Termination <input type="checkbox"/> Remove Dependent Only	<input type="checkbox"/> New Hire <input type="checkbox"/> Qualifying Event/Reason: _____ <input type="checkbox"/> Loss of Coverage (include proof—HIPAA Cert.) <input type="checkbox"/> Effective Date _____ <input type="checkbox"/> Employee Terminated <input type="checkbox"/> Open Enrollment—Transferred to another plan <input type="checkbox"/> Dissatisfaction <input type="checkbox"/> Cost <input type="checkbox"/> Spouse's Coverage <input type="checkbox"/> Other: _____ Effective Date: _____	<input type="checkbox"/> Open Enrollment <input type="checkbox"/> Moved Out of Area

AchievaCare PPO    HSA High Deductible PPO    AttentiCare EPO

SUBSCRIBER	1. First Name		M.I.	Last Name		4. Your Social Security #		6A. Employer Name		
	2. Street Address				Apt. #		5. Telephone:		6B. Chamber/Association	
	3. City		State		County		Zip Code		7. Primary language if other than English:	

8. MEMBER INFORMATION	Add	Delete	Name: Indicate different last names, if applicable. List oldest dependents first.	Date of Birth (mm/dd/yy)	Relationship	Social Security Number	Medicare A & B* Effective Date *Copy of Medicare Card must be attached.	Full-Time Student	Previous Health Care Coverage Effective Dates (Include copy of HIPAA Cert.)
	<input type="checkbox"/>	<input type="checkbox"/>	00	Applicant	/ /	Self <input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> A / / <input type="checkbox"/> B / /	
<input type="checkbox"/>	<input type="checkbox"/>	01		/ /	<input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Other		<input type="checkbox"/> A / / <input type="checkbox"/> B / /		<input type="checkbox"/> Yes Dates: / / to / / <input type="checkbox"/> No Previous Carrier: <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	02		/ /	<input type="checkbox"/> Son <input type="checkbox"/> Daughter		<input type="checkbox"/> A / / <input type="checkbox"/> B / /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes Dates: / / to / / <input type="checkbox"/> No Previous Carrier: <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	03		/ /	<input type="checkbox"/> Son <input type="checkbox"/> Daughter		<input type="checkbox"/> A / / <input type="checkbox"/> B / /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes Dates: / / to / / <input type="checkbox"/> No Previous Carrier: <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	04		/ /	<input type="checkbox"/> Son <input type="checkbox"/> Daughter		<input type="checkbox"/> A / / <input type="checkbox"/> B / /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes Dates: / / to / / <input type="checkbox"/> No Previous Carrier: <input type="checkbox"/> No

9. DEPENDENT	Full-time college students age 19 and over:		Expected Date of Graduation:
	School Name and Address:		
Do you have a disabled dependent beyond age 19? <input type="checkbox"/> No <input type="checkbox"/> Yes (list name[s]): _____			
11. SIGNATURE	<b>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 reverse side of this form.</b>		
	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.		
Applicant's Signature	Date		

10. OTHER INSURANCE	Other Coverage—Do you, your spouse, or any of your dependents have any other medical insurance that will be maintained in addition to CDPHP? <input type="checkbox"/> Yes If yes, complete below. <input type="checkbox"/> No	
	Policyholder name:	Relationship: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child
	Social Security Number:	Date of Birth: / /
	Insurance Carrier:	Policy #: _____ Effective Date: _____
	Address:	Employer Name:
	Telephone:	Covered Individuals:
Plan Type: <input type="checkbox"/> Self Only <input type="checkbox"/> Self & Family	Coverage Type: <input type="checkbox"/> Hospital <input type="checkbox"/> Medical <input type="checkbox"/> Drug <input type="checkbox"/> Dental <input type="checkbox"/> Vision	



## **IMPORTANT**

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 Universal Benefits, Inc. (CDPHP UBI) marketing department at (518) 641-5000 or 1-800-993-7299. Thank you for choosing CDPHP UBI for your health care coverage.

Your signature on the reverse of 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 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 understand that unresolved grievances are subject to the procedure specified in the Master Group Contract.

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 UBI, 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.

Note: Your 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.