



Enrollment Application/Change Form

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"/> Open Enrollment <input type="checkbox"/> Employee Terminated <input type="checkbox"/> Moved Out of Area <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: _____

Check Type of Coverage: AvidCare (CDPHP HMO) AdaptaCare (CDPHP UBI POS)

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

10. 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	Full-Time Student	You, and each dependent, must select a Primary Care Physician (PCP) . Females may also choose one OB/GYN. For all selections, indicate if you are a current patient and the Physician # and office location from the provider directory.		Physician Number	if current patient
			First M.I. Last				Effective Date		Physician First and Last Name	Office Location		
<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 / /		PCP OB/GYN			<input type="checkbox"/>
<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 / /		PCP OB/GYN			<input type="checkbox"/>
<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	PCP OB/GYN			<input type="checkbox"/>
<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	PCP OB/GYN			<input type="checkbox"/>
<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	PCP OB/GYN			<input type="checkbox"/>

11. DEPENDENT	Full-time college students age 19 and over:		Expected Date of Graduation:	12. 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 <i>If yes, complete below.</i> <input type="checkbox"/> No	
	School Name and Address:					Policyholder name:
Do you have a disabled dependent beyond age 19? <input type="checkbox"/> No <input type="checkbox"/> Yes (list name[s]):				Social Security Number:	Date of Birth: / /	
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. 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.				Insurance Carrier:	Policy #: Effective Date:	
				Address:	Employer Name:	
Applicant's Signature				Telephone:	Covered Individuals:	
Date				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 Marketing Department at (518) 641-5000 or 1-800-993-7299. Thank you for choosing CDPHP 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 Capital District Physicians' Health Plan, Inc. and/or CDPHP Universal Benefits, Inc.

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.

CDPHP COMPANIES

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