



**TRANSACTION FORM FOR GROUP ACCOUNTS**  
 MEMBERSHIP/P.O. BOX 2820 • NEW YORK, NY 10116-2820  
 (Please read important information on back before completing this form)  
 Employers: See back for sections you must complete  
**PLEASE PRINT CLEARLY**

**INTERNAL USE ONLY**  
 CONTROL NUMBER

I. SUBSCRIBER INFORMATION						
LAST NAME	FIRST NAME	M.I.	TELEPHONE NUMBERS HOME WORK		EMAIL ADDRESS	
HOME ADDRESS	APT. NO.	SOCIAL SECURITY NUMBER (REQUIRED)		GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other _____	
CITY	STATE	ZIP CODE	PRIMARY LANGUAGE SPOKEN			

II. ENROLLMENT INFORMATION											
LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH MO/DAY/YR	SOCIAL SECURITY NUMBER (REQUIRED)	GENDER	RELATIONSHIP	MAILING ADDRESS (If different from above)	Required for EH CompreHealth		ADD ✓	DELETE ✓
								PRIMARY CARE PHYSICIAN ID Number	OB/GYN SELECTION ID Number		
SUBSCRIBER						SELF					
SPOUSE											
DEPENDENT											
DEPENDENT											
DEPENDENT											

III. OTHER CARRIER INFORMATION Do you or any of your dependents have other health care coverage? <input type="checkbox"/> Yes Please complete this section <input type="checkbox"/> No GO TO SECTION IV									
NAME OF SUBSCRIBER'S OTHER INSURANCE CARRIER	INSURANCE CO. PHONE #	TYPE OF CONTRACT <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Family		NAME OF POLICYHOLDER: LAST NAME		FIRST NAME	M.I.	POLICY ID. NUMBER	EFFECTIVE DATE
NAME OF SPOUSE'S OTHER INSURANCE CARRIER/MEDICARE	INSURANCE CO. PHONE #	TYPE OF CONTRACT <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Family		NAME OF POLICYHOLDER: LAST NAME		FIRST NAME	M.I.	POLICY ID. NUMBER	EFFECTIVE DATE

IV. DID YOU HAVE PRIOR HEALTH COVERAGE? <input type="checkbox"/> YES Please provide a 12-month history of all coverage in this section (Use additional pages if you need more space) <input type="checkbox"/> NO GO TO SECTION V						
NAME AND ADDRESS OF INSURER	TELEPHONE NUMBER OF INSURER	NAME OF POLICYHOLDER		POLICY I.D. NUMBER	EFFECTIVE DATE OF CURRENT OR PRIOR POLICY	TERMINATION DATE OF CURRENT OR PRIOR POLICY

**V. PRE-EXISTING CONDITIONS**

Pre-existing conditions will not be covered during the first twelve (12) months of enrollment in the EmblemHealth CompreHealth program or during the first eleven (11) months of enrollment in the EmblemHealth EPO, EmblemHealth PPO, EmblemHealth InBalance EPO, EmblemHealth InBalance PPO, EmblemHealth ConsumerDirect PPO or EmblemHealth ConsumerDirect EPO. A pre-existing condition is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice or treatment was recommended or received during the six (6) month period prior to your enrollment date. EmblemHealth will credit the time you were covered by prior creditable health insurance coverage toward the twelve (12) month or eleven (11) month period, as long as the break in coverage between the prior coverage and your EmblemHealth coverage does not exceed sixty-three (63) days, exclusive of any waiting periods. If requested, you or your group must provide EmblemHealth with information about your pre-existing conditions and/or previous coverage. You have the right to request a certificate of creditable coverage from your prior health plan. If needed, EmblemHealth will help you get such a certificate from your prior plan.

A large group (51 or more eligible employees) may elect to cover pre-existing conditions from the start of your EmblemHealth coverage. In such a case, your EmblemHealth policy will not contain a pre-existing condition limitation or it will state that the pre-existing condition limitation does not apply.

Please call EmblemHealth at 1-877-VIA-EMBLEM (1-877-842-3625) for more information about the pre-existing condition limitation.

VI. SUBSCRIBER AUTHORIZATION	
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 five thousand dollars and the stated value of the claim for each such violation.	
If I am required to contribute to the premium for my coverage, I hereby authorize my employer to deduct such contributions in advance from wages due me and to remit same to EmblemHealth.	
Your signature is required to process this form. Your signature attests that you have read the above, and the reverse side of this form.	
Applicant must sign here _____	Date _____

**VII. EMPLOYER INFORMATION - TO BE COMPLETED BY EMPLOYER (SMALL GROUP EMPLOYERS MUST READ AND COMPLETE SECTION BELOW)**

<b>SUBSCRIBER EMPLOYMENT STATUS</b>			<b>EMPLOYEE WAITING PERIOD</b>		
<input type="checkbox"/> Employed	<input type="checkbox"/> Not Employed	<input type="checkbox"/> Retired	<input type="checkbox"/> COBRA: <input type="checkbox"/> 18 mo. <input type="checkbox"/> 36 mo.	<input type="checkbox"/> Retiree/RDS - Effective Date _____	<input type="checkbox"/> YES NUMBER OF WAITING PERIOD DAYS _____
					<input type="checkbox"/> NOT APPLICABLE
NUMBER OF ACTIVE EMPLOYEES IN YOUR GROUP _____					
<b>Check one:</b> <input type="checkbox"/> New Enrollment <input type="checkbox"/> Reinstatement <input type="checkbox"/> Termination <input type="checkbox"/> Change to Individual Policy <b>STATUS CHANGE:</b> <input type="checkbox"/> Add Dependent <input type="checkbox"/> Remove Dependent <input type="checkbox"/> Address Change <input type="checkbox"/> Name Change Reason for Change: _____ <b>TRANSFER:</b> <input type="checkbox"/> To Another Carrier <input type="checkbox"/> EmblemHealth Group # Change: From _____ To _____ Is applicant currently working at least 20 hours per week? <input type="checkbox"/> Yes <input type="checkbox"/> No					
NAME OF GROUP		GROUP NUMBER: MED/HOSPITAL: DENTAL		<b>SELECT ONE:</b> <input type="checkbox"/> EmblemHealth CompreHealth (small groups only) <input type="checkbox"/> EmblemHealth PPO <input type="checkbox"/> EmblemHealth ConsumerDirect PPO <input type="checkbox"/> EmblemHealth CompreHealth EPO (large groups only) <input type="checkbox"/> EmblemHealth InBalance EPO <input type="checkbox"/> EmblemHealth ConsumerDirect EPO <input type="checkbox"/> EmblemHealth EPO <input type="checkbox"/> EmblemHealth InBalance PPO	
<b>REQUESTED EFFECTIVE DATE</b> MEDICAL: _____ DENTAL: _____		HIRE DATE	DATE SUBMITTED TO EMBLEMHEALTH	APPROVED BY (Group Plan Administrator)/Title	TYPE OF COVERAGE: <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> FAMILY <input type="checkbox"/> EMPLOYEE & SPOUSE <input type="checkbox"/> EMPLOYEE & CHILD

**Instructions to Group Plan Administrator:** For Groups with 50 employees or less, you **MUST** complete the following documentation section. Required documentation **MUST** be attached to this Transaction Form to be processed.

<b>DOCUMENTATION BASED ON GROUP SIZE (To be completed by Small Group Plan Administrator)</b>					
ACTION Check (✓) One	Qualifying Event	Group Type (Check One) Documentation Required	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Sole Proprietorship or One Subscriber Group	Association of Two or More Employees	Small Group - Less Than 50 Employees
<input type="checkbox"/> Add Subscriber	New Hire <b>or</b> Change in Plan	For eligible employees who work more than 20 hours weekly, provide a recent copy of NYS45 showing this subscriber as an employee <b>or</b> copy of payroll documentation reflecting the date, employee's name and Social Security # <b>or</b> the employee's current year W4 form.	Not Eligible		
<input type="checkbox"/> Add Spouse	Marriage Court Order	<input type="checkbox"/> Marriage Certificate <input type="checkbox"/> Court Order			
<input type="checkbox"/> Add Dependent	Birth Adoption Court Order	<input type="checkbox"/> Birth Certificate or <input type="checkbox"/> Formal Adoption Papers or <input type="checkbox"/> Court Approved Guardianship Papers or <input type="checkbox"/> Court Order			
<input type="checkbox"/> Add Spouse <input type="checkbox"/> Add Dependent	Loss of Coverage	Certificate of Creditable Coverage			

**Note:** No retroactive enrollments will be allowed. Members must be enrolled within 30 days from the qualifying event.

<b>FOR EMBLEMHEALTH USE ONLY</b>		
PROCESSED BY _____	RECEIVED DATE _____	PROCESSED DATE _____

**IMPORTANT INFORMATION**

1. The subscriber must complete sections I through VI. The group plan administrator must complete section VII, and, if for a small group, the documentation section above.
2. All effective dates of transactions may not exceed thirty (30) days retroactive from the next billing date.
3. For group accounts with student dependent coverage: A full-time dependent student is a person who meets all of these conditions: He/she is at least 19 years of age, unmarried, receives at least half of his/her support from the employee or member, and is enrolled full-time in an accredited educational institution. The institution must grant a degree or diploma.  
To enroll the dependent as a full-time student, attach a completed Student Verification Parent Affidavit Form. See your group plan administrator or go to the EmblemHealth Web site at [www.emblemhealth.com](http://www.emblemhealth.com) for a Student Verification Parent Affidavit Form.
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.