PO Box 4181
Kingston, NY 12402-4181
(877) 244-4466

NOTICE OF ELECTION FORM

Division Number

SUBSCRIBER INFORMATION	CONTRACT HOLDER/EMPLOYER GROUP
SOCIAL SECURITY NUMBER	BUSINESS PHONE ( )

SUBSCRIBER'S LAST NAME	FIRST	MI	HOME PHONE ( )

HOME ADDRESS STREET	CITY	COUNTY	STATE	ZIP

MARITAL STATUS ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated	SPOUSE'S SOCIAL SECURITY NUMBER	SPOUSE'S EMPLOYER

CURRENT OR PRIOR HEALTH COVERAGE INFORMATION FOR THE PAST 11 MONTHS – If none please indicate below. If you have had health care coverage within the previous 11 months, please include a copy of your Certificate of Creditable Coverage from your previous insurer.

	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
Hospital						
Medical						

Will this policy be maintained in addition to this health plan? ☐ Yes ☐ No

ENROLLMENT INFORMATION (List yourself and any eligible dependents you wish to be covered by GHI HMO):

Member: Last Name (if different), First, MI		Date of Birth	Sex M	Sex F	Social Security No.	NAME AND LOCATION OF PRIMARY CARE PHYSICIAN *Required*	Currently your PCP? Yes	No	PCP #
Self		/ /							
Spouse		/ /							
Oldest Child		/ /							
Child		/ /							
Child		/ /							
Child		/ /							

Any person who, knowingly and with intent to defraud any managed care organization or other person, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, is guilty of committing a fraudulent insurance act, which is a crime and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

PRE-EXISTING CONDITION LIMITATION: If you are enrolling in a GHI HMO small group program, there will be an eleven (11) month waiting period for coverage of any condition for which medical advice, diagnosis, care or treatment was recommended or received during the six-month period ending on the enrollment date. This waiting period will be reduced to the extent that the enrollee is entitled by law to a credit for prior continuous creditable coverage. The certificate of coverage will contain more information about the pre-existing condition waiting period and the types of coverage that qualify as prior continuous creditable coverage.

AGREEMENT: I agree to choose a participating GHI HMO physician for primary care (PCP). I understand that prior approval from my GHI HMO PCP is required for all care except emergencies. I authorize my employer to deduct from my wage the amount (if any) required for coverage selected. I certify that all the information above is correct to the best of my knowledge. By signing this enrollment form, I consent to GHI HMO's release of medical records and other protected health information pertaining to myself and my enrolled family members for the for the following purposes: (1) GHI HMO's treatment, payment and healthcare operations activities; and (2) other purposes permitted or required by law and GHI HMO's Privacy Notice. I also agree that the medical records and protected health information released may include HIV, mental health or alcohol and substance abuse information about myself and my enrolled family members to the extent permitted by law. I also represent that I am authorized to give such consent(s) on behalf of my enrolled family members.

SIGN HERE: **DATE:**

☐ Individual Coverage ☐ Family Coverage	Date of Hiring / /	Effective Date of Coverage / /

NOTE: Benefits are in accordance with those described in GHI HMO's Group Contract, and summarized in GHI HMO materials. Completion of Notice of Election Form does not constitute acceptance by GHI HMO.

GHIHMO-NOE-SG-06

Copies: White and Canary/**GHI HMO or Account Representative** Pink/**Employer Group** Goldenrod/**Member**