## **Enrollment Application/Change Form**



P Copay Amt: \$ Specialist Copay Amt: \$		Linottine	.iit Applica	cition, change	. 1 01111		
Date coverage is effective		EMPLOYER USE ONL	Y .				
Retiree 65 or older   Retiree 55 - 65   Retiree Under 55		Date Hired (MM/DD/)	YY) (required)	Full-tim	Full-time Part-time (20 hours or less/we		
Date of status change		Date coverage is effect	.ive	Actively Working	○ Actively Working ○ COBRA		
Albany, NY 12206-1057   Opart-to full-time   Union to non-union   Other   Class #:   Class #:   Chamber Assoc:   Grp Admin Initials (required)				Retiree 65 or old	ler	iree Under 55	
Case #   Class		Date of status change		Employer Name			
Group/Stubproup #:   Class #:   Grp Admin Initials (required)		OPart- to full-time	Union to non-un	ion Other			
A. EXPLANATION (CHECKALL THAT APPLY)  New Hire Open Enrollment Closs of Coverage Marriage Birth Change in Student Status Dependent through 29  Name/Address Change Court Order  (COBRA—Reason: Cleft Employ/Retirement Divorce/Legal Separation Death of Spouse Dependent Reached Max Age Closs of Student Status  Termination—Reason: Cleft Employ/Retirement Divorce/Legal Separation Death of Spouse Dependent Reached Max Age Closs of Student Status  Termination—Reason: Cleft Employ/Retirement Divorce/Legal Separation Death of Spouse Dependent Reached Max Age Closs of Student Status  Termination—Reason: Cleft Death of Spouse Dependents Only Deceased Other	or	Group/Subgroup #: _		Class #:			
New Hire   Open Enrollment   Loss of Coverage   Marriage   Birth   Change in Student Status   Dependent through 29	1-800-///-22/3	Chamber Assoc:		Grp Ad	min Initials <i>(required)</i>		
Name   Address Change   Court Order	A. EXPLANATION <i>(CHECK ALL</i>	THAT APPLY)					
COBRA—Reason:   Cleft Employ/Retirement   Divorce/Legal Separation   Death of Spouse   Dependent Reached Max Age   Closs of Student Status   Cermination - Reason:   Employment Terminated   Remove Dependents Only   Deceased   Other   Deceas	New Hire Open Enrollment	○ Loss of Coverage ○	Marriage	Change in Student Status	Opendent through 29		
BLOOVERAGE INFORMATION (CHECK ALL THAT APPLY)	Name/Address Change Cour	t Order					
B. COVERAGE INFORMATION (CHECK ALL THAT APPLY)  oduct Type:   HMO   EPO   HDEPO   PPO   HDPPO   HNPO    PCopay Amt: \$ \$ Specialist Copay Amt: \$	COBRA—Reason: Left Emplo	y/Retirement ODivorce	L/Legal Separation	Death of Spouse Opepe	ndent Reached Max Age OLoss	of Student Status	
Oduct Type:	Termination—Reason:	ployment Terminated	Remove Dependent	ts Only Oeceased (	Other		
P Copay Amt: \$ Specialist Copay Amt: \$ % Coins: Deduct. Amt: \$ Deduct. Amt: \$ Delta Dental of New York Coverage mpliance with Pediatric Essential Dental Health Benefit (For employees of small groups [5:50] only). For each member 18 or younger, indicate whether tained stand-alone dental coverage that provides a pediatric dental essential health benefit through a New York Health Benefit Exchange-certified stand-alone derivation of the New York Health Benefit Exchange per order than the provider of the Company providing the stand-alone deverage. If you answer "no," we will provide you coverage of the pediatric dental essential health benefit. Additional cost may apply. Ask your employer for immalion.  C. FUNDING ACCOUNT (CHECK ALL THAT APPLY)  In participating in a CDPHN-administered:  Flexible Spending Account (FSA) Health Reimbursement Arrangement (HRA) Health Savings Account (HSA) Not Applicable  D. SUBSCRIBER INFO (CHECK ALL THAT APPLY)  It MOS only, you and each dependent MUST select a Primary Care Physician (PCP). Females may also choose one OB/GYN. Also indicate if a member is a curtient and get the Physician # and Office Location from the provider directory or at www.cdphp.com. For all other products, include copy of your MPAA certific you have Medicare Parts A and B, include a copy of your Medicare card.  Last Name  First Name  Apt. # 5. E-mail Address  City  State  ZIP  G. Employer Name  Work  Medical  Add or Deleto  Screet Address  Apt. # 5. E-mail Address  City  State  ZIP  G. Employer Name  Date of Birth  Medical  Add or Deleto  We Screet Address  Apt. # 5. E-mail Address  City  Witten:  Part A effective date:  Part A effective date:  Part B effective date:  Delta Dental  Add or Deleto  We Screet Address  Apt. # 5. E-mail Address  City  State  ZIP  Ono. (CDPHP will provide pediatric dental benefit)  We serve a part A effective date:  Delta Dental  Add or Deleto  We Screet Address  Apt. # 5. E-mail Address  City  Add or Deleto  Witten:  Delta Dental  Add or Deleto  Add or Deleto  Add or Deleto  Add or	B. COVERAGE INFORMATION	(CHECK ALL THAT APPL)	0				
P Copay Amt: \$ Specialist Copay Amt: \$ % Coins: Deduct. Amt: \$ Deduct. Amt: \$ Delta Dental of New York Coverage mpliance with Pediatric Essential Dental Health Benefit (For employees of small groups [5:50] only). For each member 18 or younger, indicate whether tained stand-alone dental coverage that provides a pediatric dental essential health benefit through a New York Health Benefit Exchange-certified stand-alone derivation of the New York Health Benefit Exchange per order than the provider of the Company providing the stand-alone deverage. If you answer "no," we will provide you coverage of the pediatric dental essential health benefit. Additional cost may apply. Ask your employer for immalion.  C. FUNDING ACCOUNT (CHECK ALL THAT APPLY)  In participating in a CDPHN-administered:  Flexible Spending Account (FSA) Health Reimbursement Arrangement (HRA) Health Savings Account (HSA) Not Applicable  D. SUBSCRIBER INFO (CHECK ALL THAT APPLY)  It MOS only, you and each dependent MUST select a Primary Care Physician (PCP). Females may also choose one OB/GYN. Also indicate if a member is a curtient and get the Physician # and Office Location from the provider directory or at www.cdphp.com. For all other products, include copy of your MPAA certific you have Medicare Parts A and B, include a copy of your Medicare card.  Last Name  First Name  Apt. # 5. E-mail Address  City  State  ZIP  G. Employer Name  Work  Medical  Add or Deleto  Screet Address  Apt. # 5. E-mail Address  City  State  ZIP  G. Employer Name  Date of Birth  Medical  Add or Deleto  We Screet Address  Apt. # 5. E-mail Address  City  Witten:  Part A effective date:  Part A effective date:  Part B effective date:  Delta Dental  Add or Deleto  We Screet Address  Apt. # 5. E-mail Address  City  State  ZIP  Ono. (CDPHP will provide pediatric dental benefit)  We serve a part A effective date:  Delta Dental  Add or Deleto  We Screet Address  Apt. # 5. E-mail Address  City  Add or Deleto  Witten:  Delta Dental  Add or Deleto  Add or Deleto  Add or Deleto  Add or		•	_	HNY			
mpliance with Pediatric Essential Dental Health Benefit. (For employees of small groups [≤50] only.) For each member 18 or younger, indicate whether italined stand-alone dental coverage that provides a pediatric dental essential health benefit through a New York Health Benefit Exchange, certified stand-alone dental coverage that provides a pediatric dental essential health benefit through a New York Health Benefit Exchange, certified stand-alone deverage. If you answer "no," we will provide you coverage of the pediatric dental essential health benefit. Additional cost may apply. Ask your employer for rormation.  C. FUNDING ACCOUNT (CHECK ALL THAT APPLY)  m participating in a CDPHN-administered:  ☐ Flexible Spending Account (FSA) ☐ Health Reimbursement Arrangement (HRA) ☐ Health Savings Account (HSA) ☐ Not Applicable ☐ DS UBSCRIBER INFO (CHECK ALL THAT APPLY)  THMOS only, you and each dependent MUST select a Primary Care Physician (PCP). Females may also choose one 0B/GYN. Also indicate if a member is a curritient and get the Physician # and Office Location from the provider directory or at <a href="https://www.cdphp.com.">www.cdphp.com.</a> . For all other products, include copy of your HIPAA certific you have Medicare Parts A and B, include a copy of your Medicare card.  Last Name ☐ First Name ☐ M.1. 4. Telephone: Home ☐ Work ☐ Medical Add or Delete		0	<u> </u>		O Delta Dental of	New York Coverage	
m participating in a CDPHN-administered:    Flexible Spending Account (FSA)   Health Reimbursement Arrangement (HRA)   Health Savings Account (HSA)   Not Applicable	stained stand-alone dental cover ental plan offered outside the Ne	age that provides a pedia w York Health Benefit Exc	atric dental essential h change. If you answer '	nealth benefit through a Ne "yes," please provide the n	ew York Health Benefit Exchange name of the company providing t	e-certified stand-alo the stand-alone den	
Flexible Spending Account (FSA)	C. FUNDING ACCOUNT <i>(CHECI</i>	K ALL THAT APPLY)					
D. SUBSCRIBER INFO (CHECK ALL THAT APPLY)  Tri HMOs only, you and each dependent MUST select a Primary Care Physician (PCP). Females may also choose one OB/GYN. Also indicate if a member is a curritient and get the Physician # and Office Location from the provider directory or at <a href="https://www.cdphp.com">www.cdphp.com</a> . For all other products, include copy of your HIPAA certification of the provider directory or at <a href="https://www.cdphp.com">www.cdphp.com</a> . For all other products, include copy of your HIPAA certification of the provider directory or at <a href="https://www.cdphp.com">www.cdphp.com</a> . For all other products, include copy of your HIPAA certification or at www.cdphp.com. For all other products, include copy of your HIPAA certification or at www.cdphp.com. For all other products, include copy of your HIPAA certification or at www.cdphp.com. For all other products, include copy of your HIPAA certification or at www.cdphp.com. For all other products, include copy of your HIPAA certification or at www.cdphp.com. For all other products, include copy of your HIPAA certification or at www.cdphp.com. For all other products, include copy of your HIPAA certification or at www.cdphp.com. For all other products, include copy of your HIPAA certification or at www.cdphp.com. For all other products, include copy of your HIPAA certification or at www.cdphp.com. For all other products, include copy of your HIPAA certification.  Medical Add or Deleta Dental Address  Apt. # 5. E-mail Address  Apt. # 5. E-mail Address  Apt. # 5. E-mail Address  Apt. # 6. Employer Name  Medical Add or Deleta Dental Coverage been obtained through an Exchange-certifical plan offered outside the Exchange?  Delta Dental Add or Deleta Dental Add or Part Beffective date:  Part A effective date:  Part A effective date:  Part B effective date:  P	m participating in a CDPHN-adm	inistered:					
THMOs only, you and each dependent MUST select a Primary Care Physician (PCP). Females may also choose one OB/GYN. Also indicate if a member is a curtient and get the Physician # and Office Location from the provider directory or at <a href="https://www.cdphp.com">www.cdphp.com</a> . For all other products, include copy of your HIPAA certification you have Medicare Parts A and B, include a copy of your Medicare card.  Last Name  First Name  First Name  Apt. # 5. E-mail Address  Apt. # 5. E-mail Address  City  State ZIP  6. Employer Name  Social Security Number (Required)  Date of Birth  Medical Add or Delete ox:	OFlexible Spending Account	(FSA)	oursement Arrangement	t (HRA)	s Account (HSA) Onot Applic	able	
tient and get the Physician # and Office Location from the provider directory or at <a href="https://www.cdphp.com">www.cdphp.com</a> . For all other products, include copy of your HPAA certification you have Medicare Parts A and B, include a copy of your Medicare card.  Last Name  First Name  Apt. # 5. E-mail Address  City  State ZIP  6. Employer Name  Social Security Number (Required)  Date of Birth  Medical Add or Delete on the part A effective date:  Part A effective date:  Part B effective date:  Delta Dental Add or Delete  Written:  Immicity (optional*):  White  Black  American Indian/Alaska Native  Asian/Pacific Islander  Hispanic/Latino  Other  Effective from:  Effective from:  Effective from:  Effective from:  To:  Wo only—Physician (PCP) Last  First  M.I. Office location  Phys #  Current Patien  Current Patien	D. SUBSCRIBER INFO (CHECK	ALL THAT APPLY)					
Street Address  Apt. # 5. E-mail Address  City State ZIP 6. Employer Name  Social Security Number (Required)  Date of Birth Medical Add or Delete of Birth Add or Delete of Birth Part A effective date:	itient and get the Physician # and	l Office Location from the	provider directory or a				
City State ZIP 6. Employer Name  Social Security Number (Required)  Date of Birth  Medical Add or Delete  Delta Dental  18 or younger, has stand-alone dental coverage been obtained through an Exchange-certified plan offered outside the Exchange?  Yes. Name of Company  No. (CDPHP will provide pediatric dental benefit)  Written:  Innicity (optional*): Spoken:  Written:  Mo only—Physician (PCP) Last First  M.I. Office location  Phys #  Current Patien  3/GYN Last  First  M.I. Office location  Phys #  Current Patien	Last Name	First Name	9	M.I. 4. Telephone:	Home Work	Mobile	
Social Security Number (Required)  Date of Birth  Medical Add or Delete ox:	Street Address		Ар	t. # 5. E-mail Addr	ess		
Add or Delete    Add or Delete	City	State	ZIP	6. Employer N	ame		
Part A effective date: Part B effective date: Delta Dental 18 or younger, has stand-alone dental coverage been obtained through an Exchange-certified plan offered outside the Exchange? Add or Delete Yes. Name of Company No. (CDPHP will provide pediatric dental benefit) imary Language (optional*): Spoken: Written: mnicity (optional*): White Black American Indian/Alaska Native Asian/Pacific Islander Hispanic/Latino Other evious coverage: Yes Previous carrier: Effective from: To: MO only—Physician (PCP) Last First M.I. Office location Phys # Current Patien S/GYN Last First M.I. Office location Phys # Current Patien S/GYN Last First M.I. Office location Phys # Current Patien S/GYN Last First M.I. Office location Phys # Current Patien S/GYN Last First M.I. Office location Phys # Current Patien S/GYN Last First M.I. Office location Phys # Current Patien S/GYN Last Phys # Current Patien S/GYN Last First M.I. Office location Phys # Current Patien S/GYN Last Phys # Current Patien Phys # Phys # Phys #	Social Security Number <i>(Require</i>	ed)		Date of Birth		Medical Add <i>or</i> Delete	
Add or Delete Oryounger, has stand-alone dental coverage been obtained through an Exchange-certified plan offered outside the Exchange?  Add or Delete Oryon No. (CDPHP will provide pediatric dental benefit)  Imaginary Language (optional*): Spoken:	ex: OM OF	Oisabled		○ End-Stage Renal Dise	ease	0 0	
Add or Delete Oryounger, has stand-alone dental coverage been obtained through an Exchange-certified plan offered outside the Exchange?  Add or Delete Oryon No. (CDPHP will provide pediatric dental benefit)  Imaginary Language (optional*): Spoken:	edicare number:	Part A el	ffective date:	9			
Yes. Name of Company						Detta Denta	
imary Language (optional*): Spoken: Written: Written: Hnicity (optional*): Spoken: Black American Indian/Alaska Native Asian/Pacific Islander Hispanic/Latino Other evious coverage: Yes Previous carrier: Effective from: To: HO only—Physician (PCP) Last First M.I. Office location Phys # Current Patien						0 0	
nnicity (optional*):						0 0	
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MO only—Physician (PCP) Last First M.I. Office location Phys # Current Patien  B/GYN Last First M.I. Office location Phys # Current Patien							
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	D/CVN Look				Dlava #		
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\*You are not required to answer. This information is important, however, as it helps us understand the diversity of our membership.

## For HMOs only, you and each dependent MUST select a Primary Care Physician (PCP). Females may also choose one OB/GYN. Also indicate if a member is a current patient and get the Physician # and Office Location from the provider directory or at www.cdphp.com. For all other products, include copy of your HIPAA certificate. If you have Medicare Parts A and B, include a copy of your Medicare card. 8a. Last M.I. SSN (Required) Date of Birth Medical Add or Delete Rel: *Spouse* ○ Other Sex: $\bigcirc M \bigcirc F$ ○ Disabled End-Stage Renal Disease $\bigcirc$ Medicare number: Part A effective date: Part B effective date: **Delta Dental** If 18 or younger, has stand-alone dental coverage been obtained through an Exchange-certified plan offered outside the Exchange? Add or Delete No. (CDPHP will provide pediatric dental benefit) Yes. Name of Company\_ $\bigcirc$ Primary Language (optional\*): Spoken: \_\_\_ Written: Ethnicity (optional\*): White Black American Indian/Alaska Native Asian/Pacific Islander Hispanic/Latino Other Previous coverage: Yes Previous carrier: \_ Effective from: To: HMO only-Physician (PCP) Last M.I. Office location Phys# **Current Patient?** $\bigcirc$ **Current Patient?** OB/GYN Last First M.I. Office location Phys# $\bigcirc$ 8b. Last First SSN (Required) Date of Birth Medical Add or Delete ○ Disabled Rel: () Son ○ Daughter ○ Full-time student? ○ End-Stage Renal Disease $\bigcirc$ Part A effective date: \_\_\_ Part B effective date: \_\_\_ Medicare number: \_ **Delta Dental** If 18 or younger, has stand-alone dental coverage been obtained through an Exchange-certified plan offered outside the Exchange? Add or Delete $\bigcirc$ Yes. Name of Company\_ No. (CDPHP will provide pediatric dental benefit) Primary Language (optional\*): Spoken: Written: Ethnicity (optional\*): White Black American Indian/Alaska Native Asian/Pacific Islander Hispanic/Latino Other School name (if student) Expected date of graduation School address (City, State, ZIP) Previous coverage: Yes Previous carrier: Effective from: HMO only-Physician (PCP) Last Office location Phys# **Current Patient?** First M.I. $\bigcirc$ M.I. Office location Phys# **Current Patient?** OB/GYN Last First SSN (Required) Date of Birth 8c. Last First Medical Add or Delete Rel: \( \sumset Son ○ Full-time student? ○ Disabled ○ End-Stage Renal Disease ( ) Daughter $\bigcirc$ Medicare number: Part A effective date: \_\_\_ Part B effective date: **Delta Dental** If 18 or younger, has stand-alone dental coverage been obtained through an Exchange-certified plan offered outside the Exchange? Add or Delete No. (CDPHP will provide pediatric dental benefit) $\bigcirc$ Yes. Name of Company Primary Language (optional\*): Spoken: Written: Ethnicity (optional\*): White Black American Indian/Alaska Native Asian/Pacific Islander Hispanic/Latino Other School name (if student) Expected date of graduation School address (City, State, ZIP) Previous coverage: Yes Previous carrier: Effective from: **Current Patient?** HMO only-Physician (PCP) Last First M.I. Office location Phys# $\bigcirc$ OB/GYN Last M.I. Office location Phys# **Current Patient?** First

**E. DEPENDENT INFO** 

*Note: Make sure you sign and date the application on the next page.* 

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E. DEPENDENT INFO Cont'd						
8d. Last	First		M.I. SSN <i>(Re</i>	quired)	Date of Birth	Medical Add <i>or</i> Delete
Rel: <i>Son Daughter</i>	○ Full-time stu	Oisabled	○ Disabled ○ End-Stage Renal Disease			
Medicare number:	Part A		Part B effective date:			
If 18 or younger, has stand-alone de	ental coverage been o	btained through	n an Exchange-certifie	d plan offered	outside the Exchange?	Add <i>or</i> Delete
Yes. Name of Company			\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	HP will provid	e pediatric dental benefit)	$\circ$
Primary Language (optional*): Spok						
Ethnicity (optional*):  White	Black America	n Indian/Alaska N	Native Asian/Pacif	ic Islander (	Hispanic/Latino Other	
School name (if student)		Expected d	ate of graduation S	chool address (	(City, State, ZIP)	
Previous coverage: O Yes Previou	ıs carrier:		Effective	from:	To:	
HMO only—Physician (PCP) Last	First N		. Office location		Phys #	Current Patient
OB/GYN Last	First	M.I.	Office location		Phys#	Current Patient
F. OTHER INSURANCE						
Do you, your spouse, or any of your dep	endents have any other	medical insuran	ce that will be maintaine	d in addition to	CDPHP? Yes: <i>If yes, complet</i>	te below. ONo
9. Policyholder name	Po	licy#	Insurance	carrier	Employer name	
Date of birth:	A	ddress:				
Effective date:	C	overage type:	○ Hospital ○ Me	dical On	rug Opental Ovision	
Covered Individuals— <i>Check all that ap</i>	ply Self O	Spouse OD	ependents			
<b>G. SIGNATURE: AGREEMENT:</b> I h that I have read the importan				reon is true a	nd complete to the best of my	knowledge and
Any person who knowingly and with any materially false information, or which is a crime, and shall also be s	conceals for the purp	ose of misleadir	ng, information concer	ning any fact r	naterial thereto, commits a frau	
10. Applicant's Signature:					11. Date:	

## IMPORTANT INFORMATION

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® member services department at (518) 641-3700 or 1-800-777-2273. Thank you for choosing CDPHP for your health care coverage.

Your signature on this application hereby affirms the following:

On behalf of myself and any dependents listed, I hereby apply for coverage under the Master Group Contract (health and/or dental, as the case may be) issued to my employer by Capital District Physicians' Health Plan, Inc. and/or CDPHP Universal Benefits, Inc. (CDPHP UBI) and/or Delta Dental of New York, 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/or Delta Dental of New York, Inc., 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. Capital District Physicians' Healthcare Network, Inc.

Delta Dental Service Plans are underwritten and administered by Delta Dental of New York, Inc.



Delta Dental of New York One Delta Drive Mechanicsburg, PA 17055 1-800-932-0783 TTY/TDD 1-888-373-3582 www.deltadentalins.com

A REGISTERED MARK OF DELTA DENTAL PLANS ASSOCIATION

\*You are not required to answer. This information is important, however, as it helps us understand the diversity of our membership.

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