



Enrollment Application/Change Form

Please clearly **PRINT** all information

P.O. Box 710, Buffalo, NY 14231-0710 independenthealth.com

KEY

- † Supporting documentation required
- ‡ If allowed by plan; supporting documentation may be required
- § Must include date of qualifying event

Employer Admin. Initials:	Date:
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To avoid a delay in your health insurance coverage, please be sure ALL SECTIONS ARE COMPLETED

What type of insurance are you applying for (select one)?

- Employer Group – actively employed COBRA Individual (application must include payment and supporting documentation)

A Coverage Information

Name of Employer (not needed for individuals not associated with employer group)

Account Number	Sub Account (if applicable)	Plan Name
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Effective Date (date the coverage for this applicant should be effective) <i>Failure to include a date in this field may result in a delay in your coverage</i>	Employee ID/Division/Union/Class (if applicable)
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B Qualifying Event Information

Enroll/Add Coverage (enter date and select reason below) Date of Qualifying Event: _____ (ex: date of hire)

Check One:

- | | | | | |
|---|---|--|---|---|
| <input type="checkbox"/> Open Enrollment | <input type="checkbox"/> New Hire § | <input type="checkbox"/> Newborn § | <input type="checkbox"/> Marriage § | <input type="checkbox"/> Relocated/transfer § |
| <input type="checkbox"/> Adoption/Guardianship† | <input type="checkbox"/> Involuntary Loss of Coverage § | <input type="checkbox"/> Change in Employment Status § | <input type="checkbox"/> Domestic Partner ‡ | <input type="checkbox"/> Enrolling COBRA coverage |
| <input type="checkbox"/> Other † _____ | | | | |

Disenroll/Cancel Coverage (enter date and select reason below) Effective date of cancellation: _____

Check One:

- | | | | | |
|---|-------------------------------------|--|--|--|
| <input type="checkbox"/> Terminate Employment | <input type="checkbox"/> Deceased | <input type="checkbox"/> Dependent Max age reached | <input type="checkbox"/> Divorced† | <input type="checkbox"/> Moved out of area |
| <input type="checkbox"/> No longer eligible | <input type="checkbox"/> Nonpayment | <input type="checkbox"/> Other coverage | <input type="checkbox"/> Layoff/Strike | |
| <input type="checkbox"/> Cancel coverage for entire family <input type="checkbox"/> Cancel coverage for all dependents only <input type="checkbox"/> Cancel coverage for the following dependents only: _____ | | | | |

Change(s) to existing plan (enter date and select reason below) Effective date of change: _____

Check One:

- | | | | | |
|----------------------------------|------------------------------------|---|------------------------------------|---|
| <input type="checkbox"/> Address | <input type="checkbox"/> Phone No. | <input type="checkbox"/> Marital status | <input type="checkbox"/> Last Name | <input type="checkbox"/> New Employment type* |
|----------------------------------|------------------------------------|---|------------------------------------|---|

***If new employment type check one box below:**

- | | | | | | |
|---------------------------------|--------------------------------|-----------------------------------|--|--------------------------------------|----------------------------------|
| <input type="checkbox"/> Active | <input type="checkbox"/> COBRA | <input type="checkbox"/> Inactive | <input type="checkbox"/> Surviving Insured | <input type="checkbox"/> TEFRA/DEFRA | <input type="checkbox"/> Retired |
|---------------------------------|--------------------------------|-----------------------------------|--|--------------------------------------|----------------------------------|

Check here if employee is changing to retired status

C Employee/Individual Information

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Social Security Number (SSN) must be provided for the employee/individual and for ALL dependents. Any applications submitted without an SSN for each employee/individual may be delayed or denied. Please see your employer's Benefit Administrator if you are unable to supply an SSN for each applicant.

Employee/Individual SSN

Employee Status if Applicable

- A (Active) R (Retired) C (Cobra)

Employee/Individual Last Name	First Name	Middle Initial
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Address (PO Box not accepted)	Apartment/Suite/Building:
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City	State	Zip	Date of Birth (MM/DD/YYYY)
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Gender (M or F)	Mobile Phone No. (include area code)	Home Phone No. (include area code)
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Email address	Primary Language: (if other than English)
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Primary Care Physician (refer to Find A Doctor tool at independenthealth.com/findadoctor)

Provider Name	Provider Address	Are you a current patient of this physician? (Y or N)
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Other Health Insurance Indicate if you or anyone else on this application will have other health insurance while enrolled with Independent Health. This is for informational purposes only, and the answers you provide will have no bearing on eligibility.

Insurance Carrier Name	Policy No./MBI	Name of Insured	Are you or anyone included on this application covered by Medicare? (Y or N)	Effective Date
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Have you obtained stand-alone dental coverage that provides a pediatric dental essential health benefit through a New York Health Benefit Exchange-certified stand-alone dental plan offered outside the New York Health Benefit Exchange? Yes No

If you answered "yes," please provide the name of the company issuing the stand-alone dental coverage. _____

If you answered "no," we will help secure this coverage through a plan underwritten and administered by Delta Dental of New York, Inc. Additional premium may apply.

Please complete reverse of application including dependent information (if applicable) and applicant signature (required)

Employee/Individual Social Security Number

SSN input boxes with dashes

Dependent #1

Dependent SSN input boxes

† Supporting documentation required

‡ If allowed by plan; supporting documentation required

Dependent SSN

Relationship to Employee/Individual

Spouse, Child, Grandchild, Legal ward, Domestic Partner, Other

Dependent/Spouse Last Name, First Name, Middle Initial, Date of Birth

Gender, Mobile Phone No., Home Phone No.

Email address, Primary Language

Primary Care Physician

Provider Name, Provider Address, Are you a current patient of this physician?

Dependent #2

Dependent SSN input boxes

† Supporting documentation required

‡ If allowed by plan; supporting documentation required

Dependent SSN

Relationship to Employee/Individual

Spouse, Child, Grandchild, Legal ward, Domestic Partner, Other

Dependent/Spouse Last Name, First Name, Middle Initial, Date of Birth

Gender, Mobile Phone No., Home Phone No.

Email address, Primary Language

Primary Care Physician

Provider Name, Provider Address, Are you a current patient of this physician?

Dependent #3

Dependent SSN input boxes

† Supporting documentation required

‡ If allowed by plan; supporting documentation required

Dependent SSN

Relationship to Employee/Individual

Spouse, Child, Grandchild, Legal ward, Domestic Partner, Other

Dependent/Spouse Last Name, First Name, Middle Initial, Date of Birth

Gender, Mobile Phone No., Home Phone No.

Email address, Primary Language

Primary Care Physician

Provider Name, Provider Address, Are you a current patient of this physician?

Certification and Consent – Signature REQUIRED

I certify that the information given on this application is current, true and correct to the best of my knowledge and I have read and agree to this statement.

I consent to any person or institution that shall have rendered health services to me or to any member of my family under the applicable coverage document to make available any photographs, records or information regarding such services to Independent Health.

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.

X Employee/Individual Signature Date:

1Independent Health™ means Independent Health Association, Inc. or Independent Health Benefits Corporation for members who enroll in a health coverage product through their employers or on their own.