



**Capital District Physicians' Health Plan, Inc.**  
 500 Patroon Creek Blvd.  
 Albany, NY 12206-1057  
 (518) 641-5000 or 1-800-993-7299

# Healthy New York Application/ Change Form

EXPLANATION		EMPLOYER USE	For CDPHP Use Only
<b>Check all that apply</b>	<b>Explanation and Effective Date</b>	Date hired ___/___/___ Date of status change ___/___/___ <input type="checkbox"/> Part- to full-time <input type="checkbox"/> Temporary to permanent <input type="checkbox"/> Union to non-union <input type="checkbox"/> Other _____	Group # Class Code
<input type="checkbox"/> New Enrollment <input type="checkbox"/> Name Change <input type="checkbox"/> Cobra Continuation <input type="checkbox"/> Add Dependent	<input type="checkbox"/> New Hire <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Qualifying Event/Reason: _____ <input type="checkbox"/> <b>Effective Date</b> _____	Date coverage is to be effective: _____ Group/Division #: _____ - _____	Effective Date
<input type="checkbox"/> Termination <input type="checkbox"/> Remove Dependent Only	<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: _____ <b>Effective Date:</b> _____	Employee Status: A. <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time ( <i>hours per week</i> ) ____ B. <input type="checkbox"/> Active <input type="checkbox"/> Retiree <input type="checkbox"/> Salaried <input type="checkbox"/> Union <input type="checkbox"/> Other Group Administrator Initials ( <i>required</i> ) _____	Territory Check Received <input type="checkbox"/>

**Section A. Applicant Information** *Please tell us who you are and how to contact you.*

First Name	Middle Initial	Last Name	Home Phone Number	Work Phone Number	Your Social Security Number
Street Address ( <i>of person applying for health insurance</i> )		Apt. Number	Mailing Address ( <i>if different</i> )		Apt. Number
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Married: Date of Marriage / /			Primary Language		
City	State	Zip	County	City	State
City	State	Zip	County	City	State

**Section B. Persons to be Covered (See instructions on back)** *Please tell us about yourself and any other family members for whom you are applying for coverage.*

Add	Delete	Name: Indicate different last names if applicable. List oldest dependents first. First Middle Initial Last	Date of Birth	Sex	Relationship to You	Social Security Number	Full-Time Student	Eligible for Medicare?	Select a Primary Care Physician. You, and each dependent, <b>must</b> select one <b>Primary Care Physician</b> . Female members may also choose one OB/GYN. For all selections, indicate if you are a current patient and the physician # from the provider directory. <b>Physician First and Last Name</b>	Physician Number	if current patient	Previous health coverage for you and each dependent.	Check all that apply
<input type="checkbox"/>	<input type="checkbox"/>	00 Applicant	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child/Stepchild <input type="checkbox"/> Other:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	PCP OB/GYN		<input type="checkbox"/>	Carrier Name Eff. Date Term. Date	Hospital Only <input type="checkbox"/> Medical/Surgical <input type="checkbox"/> Major Medical <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	01	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child/Stepchild <input type="checkbox"/> Other:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	PCP OB/GYN		<input type="checkbox"/>	Carrier Name Eff. Date Term. Date	Hospital Only <input type="checkbox"/> Medical/Surgical <input type="checkbox"/> Major Medical <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	02	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child/Stepchild <input type="checkbox"/> Other:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	PCP OB/GYN		<input type="checkbox"/>	Carrier Name Eff. Date Term. Date	Hospital Only <input type="checkbox"/> Medical/Surgical <input type="checkbox"/> Major Medical <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	03	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child/Stepchild <input type="checkbox"/> Other:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	PCP OB/GYN		<input type="checkbox"/>	Carrier Name Eff. Date Term. Date	Hospital Only <input type="checkbox"/> Medical/Surgical <input type="checkbox"/> Major Medical <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	04	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child/Stepchild <input type="checkbox"/> Other:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	PCP OB/GYN		<input type="checkbox"/>	Carrier Name Eff. Date Term. Date	Hospital Only <input type="checkbox"/> Medical/Surgical <input type="checkbox"/> Major Medical <input type="checkbox"/>

<b>Full-time college students age 19 and over:</b> Dependent Name(s)  Expected Date of Graduation: School Name and Address:	<b>Do you have a disabled dependent beyond age 19?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes (list name[s]):
	<b>Section C. Certification and Documentation</b> <i>I hereby represent to you 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.</i>
	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.
Applicant's Signature	Date

## Instructions for Healthy New York Application

*Please read these instructions when completing the Healthy New York Individual Application*

### Section B. Persons to be Covered

This section should be completed for the applicant and each person who will be covered under your Healthy New York insurance. Provide the full name, date of birth, sex, relationship, and Social Security number for each person who will be covered. Also indicate whether the person is eligible for Medicare. People who are eligible for Medicare are not eligible for Healthy New York Coverage. If there are other members of your household who will not be covered under the Healthy New York program, do not list them in this section.

#### **Who may be covered:**

The following people are eligible to be covered under your contract:

- The applicant.
- The applicant's spouse, unless you are divorced or your marriage has been annulled.
- A domestic partner for sole proprietors and employees of small groups.
- Your unmarried children under the age of 19.
- Any unmarried dependent child, regardless of age, who is incapable of self-sustaining employment because of mental retardation, mental illness or developmental disability, or because of physical handicap.
- Your unmarried children who are under 23 years of age and who are enrolled as full-time students at an accredited institution of learning.
- Children include legally adopted children, stepchildren dependent on you for support, and children for whom you are the proposed adoptive parent and who are dependent upon you during the waiting period prior to the adoption becoming final.

### **IMPORTANT**

On behalf of myself and any dependents listed, I hereby apply for coverage under the Master Group Contract issued by Capital District Physicians' Health Plan, 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 understand that unresolved grievances are subject to the procedure specified in the Master Group Contract.