Capital District Physicians' Health Plan, Inc.
500 Patroon Creek Blvd.
Albany, NY 12206-1057
(518) 641-3700 or 1-800-777-2273

PLEASE USE BLACK INK ONLY. ***For address changes and/or primary care physician changes simply call (518) 641-3700 or 1-800-777-2273. There is no need to complete this form.***
Please see reverse side of this form for important information on coverage of preexisting conditions.

Non-Group Enrollment Application/Change Form

Are you eligible for any other health insurance either as subscriber, spouse or dependent?
☐ Yes ☐ No If yes, was the plan offered through an employer? ☐ Yes ☐ No
If yes, employer name: Telephone:

Check Type of Coverage: ■ HMO ■ Point-of-Service

SUBSCRIBER

1. First Name M.I. Last Name	4. Your Social Security # ______ ______ ______ – ______ ______ – ______ ______ ______ ______	7. Type of coverage you are applying for: ☐ Individual ☐ Family
2. Street Address Apt. #	5. Marital Status: ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Married: Date of Marriage ______/______/______	8. Have you ever been a member of CDPHP? ☐ Yes ☐ No
3. City State County Zip Code	6. Telephone: Home: ( ) – Work: ( ) –	9. Primary language, if other than English:

10. MEMBER INFORMATION

You, and each dependent, **must** select a **Primary Care Physician (PCP)**. Females may also choose one OB/GYN. For all selections, indicate if you are a current patient and the physician # and office location from the provider directory.

Add	Delete	Name: Indicate different last names, if applicable. List oldest dependents first. First M.I. Last	Date of Birth (mm/dd/yy)	Relationship	Social Security Number	Physician First and Last Name	Office Location	Physician Number	✓ if current patient	Previous health coverage for you and each dependent. ***Proof of previous insurance must be attached.***	Check all that apply: Hospital Only	Medical/Surgical	Major Medical
☐	☐	00 Applicant	/ /	Self ☐ M ☐ F		PCP			☐	Carrier Name	☐	☐	☐
						OB/GYN			☐	Eff. Date Term. Date			
☐	☐	01	/ /	☐ Husband ☐ Wife ☐ Other		PCP			☐	Carrier Name	☐	☐	☐
						OB/GYN			☐	Eff. Date Term. Date			
☐	☐	02	/ /	☐ Son ☐ Daughter		PCP			☐	Carrier Name	☐	☐	☐
						OB/GYN			☐	Eff. Date Term. Date			
☐	☐	03	/ /	☐ Son ☐ Daughter		PCP			☐	Carrier Name	☐	☐	☐
						OB/GYN			☐	Eff. Date Term. Date			
☐	☐	04	/ /	☐ Son ☐ Daughter		PCP			☐	Carrier Name	☐	☐	☐
						OB/GYN			☐	Eff. Date Term. Date			

11. DEPENDENT

Full-time college students age 19 and over: School Name and Address:
Dependent Name(s)
Expected Date of Graduation:

Do you have a disabled dependent beyond age 19?
☐ No ☐ Yes (list name[s]):

13. SIGNATURES

AGREEMENT: 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.

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

NOTE: Following enrollment with CDPHP, a health questionnaire will be distributed for your completion.

12. OTHER INSURANCE

Other Coverage—Do you, your spouse, or any of your dependents have any other medical insurance that will be maintained in addition to CDPHP? ☐ **Yes** ☐ **No If yes, complete below.**

Policyholder name:	Relationship: ☐ Self ☐ Spouse ☐ Child	
Social Security Number:	Date of Birth: / /	
Insurance Carrier:	Policy #:	Effective Date:
Address:	Employer Name:	
Covered Individuals:		
Plan Type: ☐ Self Only ☐ Self & Family	Coverage Type: ☐ Hospital ☐ Medical ☐ Drug ☐ Dental ☐ Vision	
If Medicare indicate ☐ A ☐ B Effective Date / / ID # *Copy of card must be attached*		

FOR CDPHP USE ONLY

Effective Date	Group Number	Pre-existing condition? ☐ Yes ☐ No	Number of months left in pre-existing condition?
Contract Number	Date Received	Check Number	Amount

PREEXISTING CONDITIONS

If you have a preexisting condition (whether physical or mental), for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on your enrollment date for Capital District Physicians' Health Plan, Inc. (CDPHP) coverage, CDPHP may exclude coverage for that condition for a period of 12 months following your enrollment date. This preexisting condition limitation shall not exclude coverage in the case of: (1) an individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage; (2) a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage; or (3) an individual, and any dependent of such individual, who is eligible for a federal tax credit under the Federal Trade Adjustment Assistance Reform Act of 2002 and who has three months or more of creditable coverage. The previous sentence shall no longer apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage. For purposes of applying the preexisting condition limitation, the term "creditable coverage" has the meaning prescribed in Section 4318 of the Insurance Law. In determining whether a preexisting condition provision applies to you, CDPHP shall credit the time you were previously covered under creditable coverage if the previous creditable coverage was continuous to a date not more than 63 days prior to your enrollment date. CDPHP shall count a period of creditable coverage without regard to the specific benefits covered during the period. If you are considered an "eligible individual" as defined in Section 2741(b) of the federal Public Health Service Act, CDPHP shall not impose any preexisting condition exclusion.

IMPORTANT

Failure to complete any sections will result in a processing delay of your application, member ID cards and claims payment.

If you should have any questions about this Enrollment Application/Change Form, please call CDPHP Member Services at (518) 641-3700 or 1-800-777-2273. Thank you for choosing CDPHP for your health care coverage.

On behalf of myself and any dependents listed, I hereby apply for coverage under the Non-Group Contract issued to me (us) by CDPHP.

I understand that the benefits for which I (we) will be eligible are in accordance with those described in the Non-Group Contract and any attached riders. I further understand that for HMO benefits provided by CDPHP, except for emergencies, covered services must be obtained through a participating physician (unless otherwise noted in a rider) or in a participating hospital (unless otherwise noted in a rider) when admitted or referred by a participating physician (unless otherwise noted in a rider), and also that certain services may require a copayment (unless otherwise noted in a 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 Non-Group Contract.