Employer Application Form

Please Print

Capital District Physicians' Healthcare Network, Inc.
Capital District Physicians' Health Plan, Inc.
CDPHP Universal Benefits,® Inc.
6 Wellness Way
Latham, NY 12110
(518) 641-5000 or 1-800-993-7299

This application is hereby made with CDPHP for enrollment of eligible members in accordance with the contract of the employer named below for coverage subject to the group meeting group eligibility.

Group Effective Date:_____ End Date:_____ Group ID:_____

Check all that apply: ◯ Medical ◯ Delta Dental of New York

For Small Groups Only: SHOP Eligible ◯ Yes ◯ No

CDPHN-Administered Health Funding Arrangement(s):

◯ Flexible Spending Account (FSA) ◯ Health Reimbursement Arrangement (HRA) ◯ Health Savings Account (HSA) ◯ None

EMPLOYER INFORMATION *(Required)*

1. Legal company name

Fed Tax ID SIC code

Street address City State ZIP

2. Decision contact name Phone Fax

Street Address ZIP

City State E-mail

3.Billing contact name Phone Fax

Street Address ZIP

City State E-mail

4. Broker contact name Broker agency

Is this your broker of record? ◯ Y ◯ N

CLASSIFICATION OF COVERED EMPLOYEES

The group agrees that membership enrollment applications will be submitted only for eligible employees subject to the enrollment provisions set forth in the contract and subject to the following eligibility guidelines. Member enrollment applications should be submitted no later than 30 days prior to the effective date.

5. Eligible employee definition *(check one)*: ◯ Full-time only ◯ Full-time and part-time *(20 hours or more)*

SUBGROUPS

ENROLLMENT CLASS

6. Class description *(i.e., hourly and salary employees)*:_____ Class #:_____

Employer contribution % or $ Single:_____ Employee + Spouse:_____ Parent + Child(ren):_____ Family:_____ Medicare:_____

Non-Medicare retiree:_____ Employees will be terminated *(check one)*: ◯ End of month ◯ Date of termination

Continued on page 2

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7. Class description *(i.e., hourly and salary employees):* Class #:

Employer contribution % or $ Single: _____ Employee + Spouse: _____ Parent + Child(ren): _____ Family: _____ Medicare: _____

Non-Medicare retiree: _____ Employees will be terminated *(check one)*: ◯ End of month ◯ Date of termination

8. Is CDPHP sole medical carrier? ◯ Y ◯ N 9. If no, list other carriers: _____ ◯ 2nd open enrollment?

_____ Date: _____

Have you ever had coverage through CDPHP before? ◯ Y ◯ N If yes, under what legal name? _____

INTERNAL USE ONLY

Rep code: _____ Broker #: _____ Parent group ID#: _____

Facets group type: ◯ Employer Group ◯ Chamber ◯ Association

Group size: ◯ Large ◯ Small

Total replacement? ◯ Y ◯ N Send bill to: ◯ Group ◯ Subgroup ◯ Broker

Specialty products: ◯ Embrace Health ◯ Healthy Direction Medical ◯ Shared Health *(large group only)*
◯ Retrospective Premium (large group only)

Special Instructions (billing requirements, additional locations, reporting requirements, etc.):

SIGNATURE AUTHORIZATION

Please Note: Benefits on your signed rate sheet are made a part of this application and may NOT be altered or modified until contract renewal, unless statutorily mandated. Requests for changes to this application must be made in writing. Employers are responsible for the administration of any continuation of coverage.

Authorization: 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 for the claim for each such violation.

Employer's signature: _____ Date: _____

Print name: _____

Employer's title: _____

Broker's signature: _____ Date: _____

Print name: _____

Account Rep's signature: _____ Date: _____

Print name: _____

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

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