Enrollment Application/Change Form



Date of status change		• •		
Date coverage is effective		EMPLOYER USE ONLY		
Date of status change		. , , , , , ,	o o	(20 hours or less/week)
Date of status change		Date coverage is effective		
Latham, NY 12110 (S18) 641-5000 or 1-800-993-7299 A. EXPLANATION (CHECK ALL THAT APPLY) New Hire Open Enrollment Obsor of Coverage Marriage Birth Change in Student Status Dependent through 29 Name/Address Change Court Order COBRA-Reason: Left Employ/Retirement Divorce/Legal Separation Death of Spouse Dependent Reached Max Age Loss: Termination—Reason: Employment Terminated Remove Dependents Only Deceased Other B. COVERAGE INFORMATION (CHECK ALL THAT APPLY) Troduct Type: HMO EPO HDEPO PPO HDPPO HNY CPC Copay Amit S Specialist Copay Amit S Sections: Deduct. Amit: S Delta Dental of No. C. FUNDING ACCOUNT (CHECK ALL THAT APPLY) Torduct Type: HMO EPO HDEPO PPO HDPPO HNY CPC Copay Amit S Specialist Copay Amit S Sections: Deduct. Amit: S Delta Dental of No. C. FUNDING ACCOUNT (CHECK ALL THAT APPLY) Torduct Type: HMO OFF HDEPO PPO HDPPO HNY CPC Copay Amit S Specialist Copay Amit S Sections: Deduct. Amit: S Delta Dental of No. C. FUNDING ACCOUNT (CHECK ALL THAT APPLY) TO HIMOS ONLY, YOU and each dependent MUST select a Primary Care Physician (PCP). Member may also choose one OB/6YN. Also indicate if a nation and set the Physician a for Office. Location from the provider directory or at www. Acidhiba.com. For all other products, include copy of you you have Medicare Parts A and B, include a copy of your Medicare card. Last Name First Name M.I. 4. Telephone: Home Work Street Address Apt. # 5. E-mail Address Apt. # 5. E-mail Address Apt. # 5. E-mail Address Apt. # 5. E-mail Address Apt. # 6. Employer Name Hollowing are optional but help us understand the diversity of our membership. **Trimary Language (optional): Spoken: Written: **Trimirely (optional): Hispanic or Latino Mot Mot His			<u> </u>	9
Group/Subgroup #: Class #: Class #: Chamber Assoc: Group/Subgroup #: Class #: Chamber Assoc: Group Admin Initials (required)	, ,			
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Name/Address Change	EXPLANATION <i>(CHECK ALL</i>	THAT APPLY)		
COBRA—Reason:	w Hire Open Enrollment C	Loss of Coverage	○ Change in Student Status ○ Dependent the	hrough 29
Detail Committee Detail Comm	me/Address Change Court C	rder		
B. COVERAGE INFORMATION (CHECK ALL THAT APPLY) roduct Type:	BRA — <i>Reason:</i> Cleft Employ/	Retirement ODivorce/Legal Separation	Oeath of Spouse Oependent Reached M	ax Age OLoss of Student Status
roduct Type:	mination—Reason:	yment Terminated Remove Depende	ents Only Oeceased Other	
CP Copay Amt: \$ Specialist Copay Amt: \$ % Coins: Deduct. Amt: \$ Delta Dental of Not C. FUNDING ACCOUNT (CHECK ALL THAT APPLY) am participating in a CDPHN-administered:	COVERAGE INFORMATION	(CHECK ALL THAT APPLY)		
C. FUNDING ACCOUNT (CHECK ALL THAT APPLY) am participating in a CDPHN-administered: Flexible Spending Account (FSA)	ct Type:	HDEPO PPO HDPPO	HNY	
am participating in a CDPHN-administered: Flexible Spending Account (FSA) Health Reimbursement Arrangement (HRA) Health Savings Account (HSA) Not Applica D. SUBSCRIBER INFO (CHECK ALL THAT APPLY) or HMOS only, you and each dependent MUST select a Primary Care Physician (PCP). Member may also choose one OB/GYN. Also indicate if an attein and aget the Physician # and Office Location from the provider directory or at www.cdphp.com . For all other products, include copy of your flow www.cdphp.com. For all other products, include copy of your Medicare card. Last Name First Name M.I. 4. Telephone: Home Work	opay Amt: \$ Specialis	: Copay Amt: \$ % Coins:	Deduct. Amt: \$	Delta Dental of New York Coverage
am participating in a CDPHN-administered: Flexible Spending Account (FSA) Health Reimbursement Arrangement (HRA) Health Savings Account (HSA) Not Applica D. SUBSCRIBER INFO (CHECK ALL THAT APPLY) or HMOS only, you and each dependent MUST select a Primary Care Physician (PCP). Member may also choose one OB/GYN. Also indicate if an attein and aget the Physician # and Office Location from the provider directory or at www.cdphp.com . For all other products, include copy of your flow www.cdphp.com. For all other products, include copy of your Medicare card. Last Name First Name M.I. 4. Telephone: Home Work	FUNDING ACCOUNT (CHEC	K ALL THAT APPLY)		
D. SUBSCRIBER INFO (CHECK ALL THAT APPLY) or HMOs only, you and each dependent MUST select a Primary Care Physician (PCP). Member may also choose one OB/GYN. Also indicate if a natient and get the Physician # and Office Location from the provider directory or at www.cdphp.com . For all other products, include copy of you fou have Medicare Parts A and B, include a copy of your Medicare card. Last Name First Name M.I. 4. Telephone: Home Work Street Address Apt. # 5. E-mail Address City State ZIP 6. Employer Name Social Security Number (Required) 8. Date of Birth Sender: M F Non-Binary the following are optional but help us understand the diversity of our membership. Trimary Language (optional): Spoken: Written: ### Written: ### United Copy of your Medicare card Written: ### Part B effective date: Or enrollees in small group (100 or fewer full time equivalent employees): Have you obtained stand-alone dental coverage that provides a ediciatric dental essential health benefit through a New York Health Benefit Exchange-certified stand-alone dental coverage that provides a he New York Health Benefit Exchange? Mes No Fyou answered "yes," please provide the name of the company issuing the stand-alone dental coverage. You answered "no," we will provide you coverage of the pediatric dental essential health benefit. Additional cost may apply. Ask your employer for revious coverage: Yes Previous carrier: First Phys # Common Physician (PCP) Last First Phys # Common Physician (PCP) Last				
or HMOs only, you and each dependent MUST select a Primary Care Physician (PCP). Member may also choose one OB/GYN. Also indicate if a natient and get the Physician # and Office Location from the provider directory or at www.cdphp.com . For all other products, include copy of you found for you have Medicare Parts A and B, include a copy of your Medicare card. Last Name First Name M.I. 4. Telephone: Home Work Street Address Apt. # 5. E-mail Address City State ZIP 6. Employer Name Social Security Number (Required) 8. Date of Birth Sender: M F Non-Binary the following are optional but help us understand the diversity of our membership. rrimary Language (optional): Spoken: white contents of the product of the product of the provides a redictive date: Part B effective date: Or enrollees in small group (100 or fewer full time equivalent employees): Have you obtained stand-alone dental coverage that provides a redictive dental essential health benefit through a New York Health Benefit Exchange: Yes No You answered "yes," please provide the name of the company issuing the stand-alone dental coverage. You answered "no," we will provide you coverage of the pediatric dental essential health benefit. Additional cost may apply. Ask your employer for revious coverage: Yes Previous coverage: Yes Previous carrier: First Phys # Common of the products, include card. Apt. # 1. Telephone: Home Port All other products, include card. ### Address ### Apt. # 2. Telephone: Home Work ### Address Apt. # 2. Telephone: Home Work ### Apt. # 3. E-mail Address ### Address ### Address ### Apt. # 5. E-mail Address ### Address ### Apt. # 5. E-mail Addr	Flexible Spending Account (FSA	() Health Reimbursement Arrangem	ent (HRA) Health Savings Account (HSA)	○ Not Applicable
or HMOs only, you and each dependent MUST select a Primary Care Physician (PCP). Member may also choose one OB/GYN. Also indicate if a natient and get the Physician # and Office Location from the provider directory or at www.cdphp.com . For all other products, include copy of you found for you have Medicare Parts A and B, include a copy of your Medicare card. Last Name First Name M.I. 4. Telephone: Home Work Street Address Apt. # 5. E-mail Address City State ZIP 6. Employer Name Social Security Number (Required) 8. Date of Birth Sender: M F Non-Binary the following are optional but help us understand the diversity of our membership. rrimary Language (optional): Spoken: white contents of the product of the product of the provides a redictive date: Part B effective date: Or enrollees in small group (100 or fewer full time equivalent employees): Have you obtained stand-alone dental coverage that provides a redictive dental essential health benefit through a New York Health Benefit Exchange: Yes No You answered "yes," please provide the name of the company issuing the stand-alone dental coverage. You answered "no," we will provide you coverage of the pediatric dental essential health benefit. Additional cost may apply. Ask your employer for revious coverage: Yes Previous coverage: Yes Previous carrier: First Phys # Common of the products, include card. Apt. # 1. Telephone: Home Port All other products, include card. ### Address ### Apt. # 2. Telephone: Home Work ### Address Apt. # 2. Telephone: Home Work ### Apt. # 3. E-mail Address ### Address ### Address ### Apt. # 5. E-mail Address ### Address ### Apt. # 5. E-mail Addr	SUBSCRIBER INFO (CHECK	ALL THAT APPLY)		
State ZIP 6. Employer Name Social Security Number (Required) 8. Date of Birth Social Security Number (Required) 8. Date of Birth 8. Date of Birt	it and get the Physician # and O	fice Location from the provider directory or		
. City State ZIP 6. Employer Name 8. Date of Birth 9. Date of Bi	t Name	First Name	M.I. 4. Telephone: Home	Work Mobile
Social Security Number (Required) 8. Date of Birth 9. Date of Bi	eet Address	A	pt. # 5. E-mail Address	
iender:	<i>I</i>	State ZIP	6. Employer Name	
The following are optional but help us understand the diversity of our membership. In imary Language (optional): Spoken:	ial Security Number <i>(Require</i>	d)	8. Date of Birth	Medical Add <i>or</i> Delete
rimary Language (optional): Spoken: Written: _	er: O M O F O Non-B	inary		
rimary Language (optional): Spoken: Written: Written: thnicity (optional): Hispanic or Latino	llowina are ontional hut help us	understand the diversity of our membersh	in.	
Part A effective date: Part B effective date:		• •		
Part A effective date: Part B effective date:	ity (ontional):	atino Not Hispanic or Latino		
ediatric dental essential health benefit through a New York Health Benefit Exchange-certified stand-alone dental plan offered outside ne New York Health Benefit Exchange?	, , , , , , , , , , , , , , , , , , , ,	-	Part B effective date:	
you answered "yes," please provide the name of the company issuing the stand-alone dental coverage	ric dental essential health benef	it through a New York Health Benefit Exchan		
you answered "no," we will provide you coverage of the pediatric dental essential health benefit. Additional cost may apply. Ask your employer for revious coverage: Yes Previous carrier: Effective from: To: MO only—Physician (PCP) Last First Phys #	•	9	alone dental coverage.	
IMO only—Physician (PCP) Last First Phys #				your employer for rate information.
	• 0	vious carrier:	Effective from: To:	
DB/GYN Last First Phys #	only—Physician (PCP) Last	First	Phys #	Current Patient?
	'N Last	First	Phys #	Current Patient?

E. DEPENDENT INFO

For HMOs only, you and each dependent MUST s Office Location from the provider directory or at \underline{w}							
8a. Last Name	First Name		M.I.	SSN (Required)	D	ate of Birth	Add or Delete
Rel: Spouse Domestic Partner Ch	nild: OM OF (Non-Binary (Other (Gender:	Full-time stu	dent?	
Telephone: Home	Work		Mobile		E-mail Ad	ldress	
The following are optional but help us underst Primary Language (optional): Spoken:	and the diversity of c	our membership.		Written:			
Ethnicity (optional):		nic or Latino ffective date:		Part B e	ffective date:		
Delta Dental For enrollees in small group (100 or fewer full ti pediatric dental essential health benefit throug New York Health Benefit Exchange? Yes If you answered "yes," please provide the name If you answered "no," we will provide you cover	h a New York Health No e of the company issu	Benefit Exchange	e-certified one denta	stand-alone denta	l plan offered outsi	ide the	elete
Previous coverage: Yes Previous	carrier:		Effec	tive from:	To:		
HMO only—Physician (PCP) Last	First		F	Phys #		Current Patient?	
OB/GYN Last	First		F	Phys #		Current Patient?	
8b. Last Name	First Name		M.I.	SSN (Require	d)	Date of Birth	Medical Add <i>or</i> Delete
Rel: Child: M F Non-Binary Telephone: Home	Other Gender: _ Work			udent?	E-mail Ad	ldress	
The following are optional but help us under Primary Language (optional): Spoken:	stand the diversity (of our membersl	hip.	Wri	tten:		
Medicare number: Delta Dental For enrollees in small group (100 or fewer full tiressential health benefit through a New York Health New York Health Benefit Exchange? If you answered "yes," please provide the name If you answered "no," we will provide you coverage.	ne equivalent employ Ilth Benefit Exchange Yes No of the company issu	-certified stand-a	btained st lone dent ne dental	and-alone dental c al plan offered out	side	des a pediatric dental	Delta Dental Add or Delete mation.
• O					om:	To:	
HMO only—Physician (PCP) Last	First			Phys #		Current Patier	nt?
OB/GYN Last	First			Phys #		Current Patier	nt?
8c. Last Name	First Name		M.I.	SSN (Required	1)	Date of Birth	Medical Add <i>or</i> Delete
$Rel: \bigcirc Child: \bigcirc M \bigcirc F \bigcirc Non-Binary$	\bigcirc Other Gender: $_$		ll-time st	udent?			
Telephone: Home	Work		Mobile		E-mail Add	dress	
The following are optional but help us under Primary Language (optional): Spoken:	stand the diversity (of our membersl	hip.	Writ	ten:		
Ethnicity (optional): Hispanic or Latin Medicare number:		anic or Latino effective date: _		Pari	B effective date:		
Delta Dental For enrollees in small group (100 or fewer full tiressential health benefit through a New York Health Benefit Exchange? If you answered "yes," please provide the name	lth Benefit Exchange Yes No	-certified stand-a	lone dent	al plan offered out	side	des a pediatric dental	Delta Dental Add <i>or</i> Delete
If you answered "no," we will provide you cover		-				ur employer for rate inform	mation.
Previous coverage: Yes Previous					om:		
HMO only—Physician (PCP) Last	First			Phys #		Current Patier	nt?
OB/GYN Last	First			Phys #		Current Patier	nt?

8d. Last Name	First Name	M.I.	SSN (Required)	Date of Birth	Medical Add <i>or</i> Delete
Rel: OChild: M OF Non-Binar	y Other Gender:	Full-time stu	dent?		
Telephone: Home	Work	Mobile		E-mail Address	
The following are optional but help us und	derstand the diversity	of our membership.			
Primary Language <i>(optional):</i> Spoken:			Written:		
Ethnicity (optional): Hispanic or La	tino Not Hisp	oanic or Latino			
Medicare number:	Part /	A effective date:	Part B effecti	ve date:	
Delta Dental				hat was idea a nadiatria dantal	Delta Dental
For enrollees in small group (100 or fewer full essential health benefit through a New York I				nai provides a pediatric dental	Add or Delete
the New York Health Benefit Exchange?	Yes No				0 0
If you answered "yes," please provide the na	me of the company iss	uing the stand-alone dental co	overage.		
f you answered "no," we will provide you cov	verage of the pediatric	dental essential health benefi	t. Additional cost may app	ly. Ask your employer for rate informati	on.
Previous coverage: Yes Previo	ous carrier:		Effective from:	To:	_
HMO only—Physician (PCP) Last	First		Phys #	Current Patient?	
OD /CVALL4			Dl #		
OB/GYN Last	First		Phys #	Current Patient?	
F. OTHER INSURANCE					
Do you, your spouse, or any of your depend	dents have any other i	medical insurance that will b	e maintained in addition	to CDPHP? Yes: If yes, complet	te below. ONO
9. Policyholder Name	Polic	y #	Insurance carrier	Employer name	
Date of Birth	Addı	ress			
Effective date:		rage type:		Opental Vision	
		pouse Opendents			
Covered Individuals—Check all that apply					

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.

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. (HMO products) and/or CDPHP Universal Benefits, ® Inc. (CDPHP UBI) (EPO/PPO/HD products) 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.

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



A REGISTERED MARK OF DELTA DENTAL PLANS ASSOCIATION

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