USE BLACK INK ONLY.

Student Health Plan Enrollment Application/Change Form

500 Patroon Creek Blvd.
Albany, NY 12206-1057
(518) 641-3700 or 1-800-777-2273

A. EXPLANATION *(CHECK ALL THAT APPLY)*

Student:

- ◯ Early Enrollment
- ◯ Late Enrollment
- ◯ Voluntary Enrollment

Eligible:

- ◯ New Enrollment
- ◯ Part-time/Graduate Student
- ◯ 90-Day Extension

B. COVERAGE INFORMATION

Requested Effective date: _____

School Name: _____

Student Name & ID Number: _____

C. SUBSCRIBER INFO

1. Last Name _____ First Name _____ M.I. _____

2a. Street Address _____ Apt. # _____

2b. City _____ State ____ ZIP _____

3a. Mailing Address ◯ Check here if same as street address Apt. # _____

3b. City _____ State ____ ZIP _____

4. Telephone: Primary _____ Secondary _____

5. E-mail Address _____

6. Social Security Number ***(Required)*** _____

7. Date of Birth ***(Required)*** _____

Sex: ◯ *M* ◯ *F*

Primary Language *(optional*)*: Spoken: _____ Written: _____

Ethnicity *(optional*)*: ◯ White ◯ Black ◯ American Indian/Alaska Native ◯ Asian/Pacific Islander ◯ Hispanic/Latino ◯ Other

**You are not required to answer. This information is important, however, as it helps us understand the diversity of our membership.*

Note: Make sure you sign and date the application below.

D. SIGNATURE: AGREEMENT:

I hereby represent 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 last page 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.

4. Subscriber's Signature: _____ 5. Date: _____

IMPORTANT INFORMATION

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 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, I hereby apply for coverage under the Student Health Plan Contract issued by Capital District Physicians' Health Plan, Inc. and/or CDPHP Universal Benefits,® Inc. (CDPHP UBI), 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 Individual 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 directly to the provider of such services.

I understand that unresolved grievances are subject to the procedure specified in the Student Health Plan Contract.

CDPHP COMPANIES
Capital District Physicians' Health Plan, Inc.
CDPHP Universal Benefits,® Inc.
Capital District Physicians' Healthcare Network, Inc.

Pending approval by the New York State Department of Financial Services