PLEASE PRINT. *For address and/or primary care physician changes call (518) 641-3700, 1-800-777-2273, or visit www.cdphp.com* USE BLACK INK ONLY.
Note: You cannot purchase an individual plan if you are enrolled in Medicare.

Individual Plans Enrollment Application/Change Form

6 Wellness Way
Latham, NY 12110
(518) 641-3700 or 1-800-777-2273

A. EXPLANATION *(CHECK ALL THAT APPLY)*

Reason for applying (Qualifying life event)

New Enrollment:
- ◯ Open Enrollment
- ◯ Birth of a Child
- ◯ Loss of Coverage
- ◯ Marriage
- ◯ Court Order
- ◯ Other: *(Reason and date of qualifying event)* _____

Change Enrollment:
- ◯ Termination
- ◯ Member Requested
- ◯ Remove Dependents Only
- ◯ Deceased
- ◯ Other: *(Reason and date of qualifying event)* _____

B. COVERAGE INFORMATION *(CHECK ALL THAT APPLY)*

Requested Effective date: _____ Is this for Child-Only coverage? ◯ No ◯ Yes (If yes, you must select a Standard plan.)

If Yes, indicate name of Responsible Adult: _____

Do you have other children enrolled in a CDPHP Child-Only plan? If so, please list names: _____

Please select your plan and applicable riders.

- ◯ HDHMO HSA Qualified 44 Bronze*
- ◯ HDHMO HSA Qualified 40 Bronze Standard*
- ◯ HMO Hybrid 13 Platinum
- ◯ HMO Copayment 10 Platinum Standard
- ◯ HDHMO HSA Qualified 33 Silver*
- ◯ HMO Copayment 30 Silver Standard
- ◯ HDHMO HSA Qualified 45 Bronze*
- ◯ HDHMO Non-Qualified 60 Bronze
- ◯ HMO Triple Zero 24 Gold
- ◯ HMO Copayment 20 Gold Standard
- ◯ HMO Copayment 14 Platinum
- ◯ HDHMO HSA Qualified 35 Silver*

Optional riders:

- ◯ Dependent through Age 29 Coverage

C. SUBSCRIBER INFO

For **HMOs only,** you and each dependent **MUST** select a Primary Care Physician (PCP). Member may also choose one OB/GYN. Also indicate if a member is a current patient and get the Physician # and Office Location from the provider directory or at www.cdphp.com.

You must fill out the following section: Would you like to be added to the Donate Life Registry? Check box ◯ for yes or skip this question.

By checking 'Yes' and signing this application, you are consenting to enroll in the New York State Donate Life Registry (Registry). To modify your gift or withdraw from the Registry go to: donatelife.ny.gov or call the Registry at 1-866-NY-DONOR.

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 _____

Gender: ◯ *M* ◯ *F* ◯ *Non-Binary*

Medical ◯ **Add** **or** ◯ **Delete**

The following are optional but help us understand the diversity of our membership.

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

Ethnicity (optional): ◯ Hispanic or Latino ◯ Not Hispanic or Latino

Have you obtained stand-alone dental coverage that provides a pediatric dental essential health benefit through a New York Health Benefit Exchange-certified stand-alone dental plan offered outside the New York Health Benefit Exchange? ◯ Yes ◯ No

If you answered "yes," please provide the name of the company issuing the stand-alone dental coverage. _____

If you answered "no," we will provide you coverage of the pediatric dental essential health benefit. Additional cost may apply. See rate sheet for your county.

Previous coverage: ◯ Yes Previous carrier: _____ Effective from: _____ To: _____

HMO only—Physician (PCP) Last _____ First _____ Phys # _____ Current Patient? _____

OB/GYN Last _____ First _____ Phys # _____ Current Patient? _____

Continued on page 2

D. DEPENDENT INFO

For **HMOs only,** you and each dependent **MUST** select a Primary Care Physician (PCP). Member may also choose one OB/GYN. Also indicate if a member is a current patient and get the Physician # and Office Location from the provider directory or at www.cdphp.com.

8a. Last Name | First Name | M.I. | SSN ***(Required)*** | Date of Birth | **Medical Add *or* Delete**

Rel: ◯ Spouse ◯ Domestic Partner Gender: ◯ *M* ◯ *F* ◯ *Non-Binary*

Telephone: Home _____ Work _____ Mobile _____ E-mail Address _____

The following are optional but help us understand the diversity of our membership.

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

Ethnicity (optional): ◯ Hispanic or Latino ◯ Not Hispanic or Latino

Have you obtained stand-alone dental coverage that provides a pediatric dental essential health benefit through a New York Health Benefit Exchange-certified stand-alone dental plan offered outside the New York Health Benefit Exchange? ◯ Yes ◯ No

If you answered "yes," please provide the name of the company issuing the stand-alone dental coverage. _____

If you answered "no," we will provide you coverage of the pediatric dental essential health benefit. Additional cost may apply. See rate sheet for your county.

Previous coverage: ◯ Yes Previous carrier: _____ Effective from: _____ To: _____

HMO only—Physician (PCP) Last | First | Phys # | Current Patient?

OB/GYN Last | First | Phys # | Current Patient?

8b. Last Name | First Name | M.I. | SSN ***(Required)*** | Date of Birth | **Medical Add *or* Delete**

Rel: ◯ Child ◯ Other Gender: ◯ *M* ◯ *F* ◯ *Non-Binary*

Telephone: Home _____ Work _____ Mobile _____ E-mail Address _____

The following are optional but help us understand the diversity of our membership.

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

Ethnicity (optional): ◯ Hispanic or Latino ◯ Not Hispanic or Latino

Have you obtained stand-alone dental coverage that provides a pediatric dental essential health benefit through a New York Health Benefit Exchange-certified stand-alone dental plan offered outside the New York Health Benefit Exchange? ◯ Yes ◯ No

If you answered "yes," please provide the name of the company issuing the stand-alone dental coverage. _____

If you answered "no," we will provide you coverage of the pediatric dental essential health benefit. Additional cost may apply. See rate sheet for your county.

Previous coverage: ◯ Yes Previous carrier: _____ Effective from: _____ To: _____

HMO only—Physician (PCP) Last | First | Phys # | Current Patient?

OB/GYN Last | First | Phys # | Current Patient?

8c. Last Name | First Name | M.I. | SSN ***(Required)*** | Date of Birth | **Medical Add *or* Delete**

Rel: ◯ Child ◯ Other Gender: ◯ *M* ◯ *F* ◯ *Non-Binary*

Telephone: Home _____ Work _____ Mobile _____ E-mail Address _____

The following are optional but help us understand the diversity of our membership.

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

Ethnicity (optional): ◯ Hispanic or Latino ◯ Not Hispanic or Latino

Have you obtained stand-alone dental coverage that provides a pediatric dental essential health benefit through a New York Health Benefit Exchange-certified stand-alone dental plan offered outside the New York Health Benefit Exchange? ◯ Yes ◯ No

If you answered "yes," please provide the name of the company issuing the stand-alone dental coverage. _____

If you answered "no," we will provide you coverage of the pediatric dental essential health benefit. Additional cost may apply. See rate sheet for your county.

Previous coverage: ◯ Yes Previous carrier: _____ Effective from: _____ To: _____

HMO only—Physician (PCP) Last | First | Phys # | Current Patient?

OB/GYN Last | First | Phys # | Current Patient?

Continued on page 3

D. DEPENDENT INFO Cont'd

8d. Last Name | First Name | M.I. | SSN ***(Required)*** | Date of Birth | **Medical Add *or* Delete**

Rel: ◯ Child ◯ Other Gender: ◯ *M* ◯ *F* ◯ *Non-Binary*

Telephone: Home _____ Work _____ Mobile _____ E-mail Address _____

The following are optional but help us understand the diversity of our membership.

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

Ethnicity (optional): ◯ Hispanic or Latino ◯ Not Hispanic or Latino

Have you obtained stand-alone dental coverage that provides a pediatric dental essential health benefit through a New York Health Benefit Exchange-certified stand-alone dental plan offered outside the New York Health Benefit Exchange? ◯ Yes ◯ No

If you answered "yes," please provide the name of the company issuing the stand-alone dental coverage. _____

If you answered "no," we will provide you coverage of the pediatric dental essential health benefit. Additional cost may apply. See rate sheet for your county.

Previous coverage: ◯ Yes Previous carrier: _____ Effective from: _____ To: _____

HMO only—Physician (PCP) Last | First | Phys # | Current Patient?

OB/GYN Last | First | Phys # | Current Patient?

E. OTHER INSURANCE

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

9. Policyholder Name | Policy # | Insurance carrier | Employer name

Date of Birth _____ Address _____

Effective date: _____ Coverage type: ◯ Hospital ◯ Medical ◯ Drug ◯ Dental ◯ Vision

Covered Individuals—Check all that apply ◯ Self ◯ Spouse ◯ Dependents

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

F. 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.

10. Applicant's Signature: _____ 11. Date: _____

(For Child-Only Plans: Responsible Adult Signature.)

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 and any dependents listed, I hereby apply for coverage under the Individual 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 (or my dependents) directly to the provider of such services.

I understand that unresolved grievances are subject to the procedure specified in the Individual Contract.

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

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

DELTA DENTAL®

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