

# Enrollment Application/Change Form



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

## EMPLOYER USE ONLY

Date Hired (MM/DD/YY) (required) \_\_\_\_\_  Full-time  Part-time (20 hours or less/week)

Date coverage is effective \_\_\_\_\_  Actively Working  COBRA  
 Retiree 65 or older  Retiree 55-65  Retiree Under 55

Date of status change \_\_\_\_\_ Employer Name \_\_\_\_\_  
 Part- to full-time  Union to non-union  Other \_\_\_\_\_

Group/Subgroup #: \_\_\_\_\_ Class #: \_\_\_\_\_

Chamber Assoc: \_\_\_\_\_ Grp Admin Initials (required) \_\_\_\_\_

## A. EXPLANATION (CHECK ALL THAT APPLY)

New Hire  Open Enrollment  Loss 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 of Student Status

Termination—Reason:  Employment Terminated  Remove Dependents Only  Deceased  Other \_\_\_\_\_

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

Product Type:  HMO  EPO  HDEPO  PPO  HDPPPO  HNY

PCP Copay Amt: \$ \_\_\_\_\_ Specialist Copay Amt: \$ \_\_\_\_\_ % Coins: \_\_\_\_\_ Deduct. Amt: \$ \_\_\_\_\_  Delta Dental of New York Coverage

## C. FUNDING ACCOUNT (CHECK ALL THAT APPLY)

I am participating in a CDPHN-administered:

Flexible Spending Account (FSA)  Health Reimbursement Arrangement (HRA)  Health Savings Account (HSA)  Not Applicable

## D. SUBSCRIBER INFO (CHECK ALL THAT APPLY)

For HMOs only, you and each dependent MUST select a Primary Care Physician (PCP). Females 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](http://www.cdphp.com). For all other products, include copy of your HIPAA certificate. If you have Medicare Parts A and B, include a copy of your Medicare card.

1. Last Name _____	First Name _____	M.I. _____	4. Telephone: Home _____	Work _____	Mobile _____
2. Street Address _____	Apt. # _____		5. E-mail Address _____		
3. City _____	State _____	ZIP _____	6. Employer Name _____		
7. Social Security Number (Required) _____			Date of Birth _____		Medical Add or Delete <input type="radio"/>

Sex:  M  F  Disabled  End-Stage Renal Disease

Medicare number: \_\_\_\_\_ Part A effective date: \_\_\_\_\_ Part B effective date: \_\_\_\_\_

For enrollees in small group (100 or fewer full time equivalent employees): 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. Ask your employer for rate information.

Primary Language (optional\*): Spoken: \_\_\_\_\_ Written: \_\_\_\_\_

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

Previous coverage:  Yes Previous carrier: \_\_\_\_\_ Effective from: \_\_\_\_\_ To: \_\_\_\_\_

HMO only—Physician (PCP) Last _____	First _____	Phys # _____	Current Patient? <input type="radio"/>
OB/GYN Last _____	First _____	Phys # _____	Current Patient? <input type="radio"/>

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

**E. DEPENDENT INFO**

For **HMOs only**, you and each dependent **MUST** select a Primary Care Physician (PCP). Females 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](http://www.cdphp.com). For all other products, include copy of your HIPAA certificate. If you have Medicare Parts A and B, include a copy of your Medicare card.

8a. Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ SSN (Required) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Rel:  Spouse  Other Sex:  M  F  Disabled  End-Stage Renal Disease

Medical Add or Delete

Medicare number: \_\_\_\_\_ Part A effective date: \_\_\_\_\_ Part B effective date: \_\_\_\_\_

Delta Dental Add or Delete

For enrollees in small group (100 or fewer full time equivalent employees): 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. Ask your employer for rate information.

Primary Language (optional\*): Spoken: \_\_\_\_\_ Written: \_\_\_\_\_

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

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 \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ SSN (Required) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Rel:  Son  Daughter  Full-time student?  Disabled  End-Stage Renal Disease

Medical Add or Delete

Medicare number: \_\_\_\_\_ Part A effective date: \_\_\_\_\_ Part B effective date: \_\_\_\_\_

Delta Dental Add or Delete

For enrollees in small group (100 or fewer full time equivalent employees): 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. Ask your employer for rate information.

Primary Language (optional\*): Spoken: \_\_\_\_\_ Written: \_\_\_\_\_

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

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 \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ SSN (Required) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Rel:  Son  Daughter  Full-time student?  Disabled  End-Stage Renal Disease

Medical Add or Delete

Medicare number: \_\_\_\_\_ Part A effective date: \_\_\_\_\_ Part B effective date: \_\_\_\_\_

Delta Dental Add or Delete

For enrollees in small group (100 or fewer full time equivalent employees): 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. Ask your employer for rate information.

Primary Language (optional\*): Spoken: \_\_\_\_\_ Written: \_\_\_\_\_

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

Previous coverage:  Yes Previous carrier: \_\_\_\_\_ Effective from: \_\_\_\_\_ To: \_\_\_\_\_

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

OB/GYN Last \_\_\_\_\_ First \_\_\_\_\_ Phys # \_\_\_\_\_ Current Patient?

**Note: Make sure you sign and date the application on the next page.**

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

**E. DEPENDENT INFO Cont'd**

8d. Last First M.I. SSN (Required) Date of Birth Medical Add or Delete
Rel: Son Daughter Full-time student? Disabled End-Stage Renal Disease
Medicare number: Part A effective date: Part B effective date: Delta Dental Add or Delete
For enrollees in small group (100 or fewer full time equivalent employees): 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. Ask your employer for rate information.
Primary Language (optional\*): Spoken: Written:
Ethnicity (optional\*): White Black American Indian/Alaska Native Asian/Pacific Islander Hispanic/Latino Other
Previous coverage: Yes Previous carrier: Effective from: To:
HMO only—Physician (PCP) Last First Phys # Current Patient?
OB/GYN Last First Phys # Current Patient?

**F. 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

**G. 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:

**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.



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

A REGISTERED MARK OF DELTA DENTAL PLANS ASSOCIATION

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