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.

# 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 ◯ HDPPO ◯ 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. **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. _____

2. Street Address _____ Apt. # _____

3. City _____ State ____ ZIP _____

4. Telephone: Home _____ Work _____ Mobile _____

5. E-mail Address _____

6. Employer Name _____

7. Social Security Number ***(Required)*** _____ Date of Birth _____

**Medical Add *or* Delete** ◯ ◯

Sex: ◯ *M* ◯ *F* ◯ 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 (50 or fewer eligible 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 | M.I. | Office location | Phys # | Current Patient? |
|---|---|---|---|---|---|
| | | | | | ◯ |
| OB/GYN Last | First | M.I. | Office location | Phys # | Current Patient? |
| | | | | | ◯ |

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



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## 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. **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 | **Medical Add *or* Delete**

Rel: ◯ *Spouse* ◯ *Other* Sex: ◯ *M* ◯ *F* ◯ 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 (50 or fewer eligible 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 | M.I. | Office location | Phys # | Current Patient?

OB/GYN Last | First | M.I. | Office location | Phys # | Current Patient?

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8b. 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 (50 or fewer eligible 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

School name *(if student)* | Expected date of graduation | School address *(City, State, ZIP)*

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

*HMO only*—Physician (PCP) Last | First | M.I. | Office location | Phys # | Current Patient?

OB/GYN Last | First | M.I. | Office location | Phys # | Current Patient?

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8c. 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 (50 or fewer eligible 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

School name *(if student)* | Expected date of graduation | School address *(City, State, ZIP)*

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

*HMO only*—Physician (PCP) Last | First | M.I. | Office location | Phys # | Current Patient?

OB/GYN Last | First | M.I. | Office location | Phys # | Current Patient?

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***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.*



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## 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 (50 or fewer eligible 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

School name *(if student)* | Expected date of graduation | School address *(City, State, ZIP)*

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

*HMO only*—Physician (PCP) Last | First | M.I. | Office location | Phys # | Current Patient? ◯

OB/GYN Last | First | M.I. | Office location | 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. 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 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.
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

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