# Application for Individual Off-Exchange Direct Pay HMO

# **Instructions**

- Please type or print firmly with ballpoint pen.
- This application may be used to apply for new enrollment, or to change your type of contract. Complete this application if you or your spouse, or both, are not eligible for Medicare due to age. Your contract should be appropriate (Individual, Family, Child Only, Self/Spouse & Self/Child) to your status as indicated below:

# Individual

- If you are unmarried, widowed, divorced, or legally separated and have no dependent children.
- If you are married without dependent children, and each spouse would prefer their own individual contract.
- If your spouse is Medicare eligible, and/or you have dependents under the age of 26 and do not wish to purchase a policy that covers dependents.

# Self/Spouse, Self/Child, and Family

- If you are married, or if you are married with dependent children. If you are married and your spouse is eligible for Medicare, and you're covering one or more dependents under age 26, you should apply for a desired contract for you and your child(ren). Your Medicare-eligible spouse should apply for separate coverage using a Non-Group Medicare Supplement Insurance Application Form.
- If you are unmarried, widowed, divorced, or legally separated and you're covering one or more dependent children.
- If you have one or more dependent children under 26 years of age, complete only one application for desired coverage for yourself and your children.

# **Child Only**

- If you are purchasing coverage for a child only. This contract will not provide coverage for the Responsible Adult.
- If you are the Responsible Adult for a child under 21 years of age. Children covered under this contract include natural children, legally adopted children, step children, children for whom the Responsible Adult is the proposed adoptive parent, and children for whom the Responsible Adult is the legal guardian. Foster children and grandchildren of the Responsible Adult are not covered.
- If you would like to purchase a Child Only contract for more than one child, please complete a separate application for each additional child.
- When submitting your completed application, you must include a check or money order.
- All applicants must:
  - 1. Complete, sign, and date the application where indicated.
  - 2. Check the appropriate boxes for type of coverage and type of contract.
  - 3. Return the completed application with a check or money order to:

EmblemHealth ATTN: IND DM Sales Direct Pay 55 Water Street, 8th Floor New York, NY 10041-8190

Payable Amount \$	Check No.	Money Order No.
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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 five thousand dollars and the stated value of the claim for each such violation.

EmblemHealth individual payment plans are underwritten by Health Insurance Plan of Greater New York (HIP).

EmblemHealth Plan, Inc., EmblemHealth Insurance Company, EmblemHealth Services Company, LLC and Health Insurance Plan of Greater New York (HIP) are EmblemHealth companies. EmblemHealth Services Company, LLC provides administrative services to the EmblemHealth companies.

155-23-HIXIAPP (04/25) 10-8089 05/25

# **PRINT IN INK**

	t: □ Individual   Requested Plan sta		al & Spouse 〔	□P	arent & Child(ren	) 🗆	Family	(Individual/Spouse & Cl	hild(	ren)	☐ Child Only
Please specify P	·										
	ow are part of our S Platinum D Sele Gold D Sele	ect Care Bı			Plans listed belo  Millennium P  Millennium G  Millennium S	latin Gold [	um D D	of our Millennium Netwo □ Millennium Bronze			
• All enrollees/inhealth insurar		g enrollme	ent after the e	nd d	of Open Enrollme	nt mı	ust hav	e a qualifying life event	in or	der t	o be eligible for
• Please check I	here if you are you a	applying at	fter the end of	Ор	en Enrollment wi	ith a	qualifyi	ng life event. $\square$			
	n option for yourself and a be at least 16 years old in					fe Regi	stry for o	rgan, eye, and tissue donation			
1. Please compl	ete the following	informatio	on for the sub	SC	riber.						
Subscriber's Last N	ame		First Name			M.I.		Date of Birth (MM/DD/YY)		Social	Security Number
	were you assigned at b										
☐ Male Gender Identity: Wh	☐ Female nat is your current gend	☐ Gender X er identity:			Unknown						
☐ Male	☐ Female er X, Genderqueer, or third	☐ Transgen	der male/female-t □ Other: Prefer					☐ Transgender female/ male☐ Choose not to disclose	-to-fei	male (N	MTF)
☐ He/him  Accessible format:	□ She/her	☐ They/the	m		Choose not to disclose	)					
☐ Not Applicable	:	☐ B-Braille	0		L -Large Print			☐ A-Audio CD	□С	hoose	not to disclose
☐ Straight or heterosexual ☐ Choose not to disc	ich of the following bes  ☐ Lesbian or gay close	□ Bisexual	ou?		Queer, pansexual, and, questioning	/or		☐ Don't know			otion not specified ling else)
Ethnicity: Are you o	f Hispanic, Latino/a or	Spanish Orig	in?								
<ul><li>No, not of Hispanion</li><li>Spanish origin</li><li>☐ Yes, Cuban</li></ul>	c, Latino/a, or	☐ Yes, Puer☐ Choose n	to Rican ot to disclose		Yes, Dominican			☐ Yes, Mexican, Mexican American Chicano/a			ne Other Hispanic, ı, or Spanish Origin
	ry best describes your i										
☐ Black or African American ☐ Filipino	☐ White ☐ Japanese	☐ Asian Ind			American Indian or Ala Vietnamese	aska Na	ative	☐ Native Hawaiian ☐ Other Asian		hinese amoan	
☐ Guamanian or Chamorro	☐ Other Pacific Islander	African	astern or North		Two or more races			☐ Some other race	□с	hoose	not to disclose
	our preferred language		-	_							
☐ English ☐ Bengali ☐ Polish ☐ Portuguese	□ Spanish □ Yiddish □ Tagalog □ Hindi	☐ Chinese, ☐ French ☐ Greek ☐ Americar	Cantonese Sign Language		Chinese, Mandarin Italian Albanian Other Language			☐ Russian ☐ Korean ☐ Urdu ☐ Choose not to disclose	ΠА	rench ( rabic ietnam	Creole (Haitian Creole) nese
Home Address (P.C	). Box is not acceptable	e)			Telephone Number	rs					
Cell: Home:							Work:				
City								State ZIP Code			ode
Mailing Address (If different from Home Address)								<sup>†</sup> Donate Life Registry ☐ Yes	s 🗆	Skip fo	r now
City					County			State		ZIP Co	ode
Applicant Email Ad	Applicant Email Address PCP Name/ID Number Go Paperless" (see below)										

By electing "Go paperless," you will receive claim statements and some other EmblemHealth letters by email instead of paper mail. You will be able to view your Explanation of Benefits (EOBs) under the Claims portal of the EmblemHealth Website. Your enrollment in the "Go Paperless" option will continue as long as your account remains active, or until you choose to discontinue this option.

By completing this form, I consent to receive calls from a representative about EmblemHealth products and services at the number I have provided (including mobile devices). These calls may be made using an automated technology and my consent to receive these calls is not required as a condition for me to make a purchase.

Disclosure of race, ethnicity, language, sexual orientation or gender identity will not impact underwriting, denial of services, coverage and benefits, or be disclosed to unauthorized users.

Personal preferences may be updated within the Member Portal, once an account is created.

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<ol> <li>Please complete the following spouse and/or dependent child(ren) information if applying for a Family Contract.</li> <li>A dependent child will be covered until the end of the month in which he/she becomes 26 years of age.</li> </ol>											
Spouse/Dependent	's Last Name	First Name			M.I.	Date of Bi	irth (M	1M/DD/YY)	Relationship	)	Telephone (Daytime)
Mailing Address (If	different from above)	<u>'</u>				Email Add	dress				1
Social Security Num	nber		PCP Nam	ne/ID I	Number		†Doı	nate Life Regist	ry 🗌 Yes 🗀	Skip fo	r now
Birth Sex: What sex	were you assigned at b	irth?	I								
☐ Male	□ Female	☐ Gender X		Unknov	wn						
Gender Identity: Wh  ☐ Male	at is your current gend	er identity:  ☐ Transgender male/fe	mala ta mal	lo (ETN	A)			□ Transganda	r famala/ mala	to form	olo (MTF)
	r X, Genderqueer, or third		Prefer to sel					☐ Transgende☐ Choose not		-to-iem	ale (MTF)
☐ He/him Accessible format:	☐ She/her	☐ They/them		Choose	e not to disclos	е					
☐ Not Applicable	ich of the following bes	☐ B-Braille		L -Larg	ge Print			☐ A-Audio CD		□ Ch	pose not to disclose
☐ Straight or heterosexual ☐ Choose not to disc	☐ Lesbian or gay lose	□ Bisexual		Queer, questic	pansexual, and oning	d/or		☐ Don't know			ner option not specified mething else)
	f Hispanic, Latino/a or										
☐ No, not of Hispanic Spanish origin ☐ Yes, Cuban	c, Latino/a, or	☐ Yes, Puerto Rican☐ Choose not to disclos		Yes, Do	ominican			☐ Yes, Mexica American C	*		s, Some Other Hispanic, ino/a, or Spanish Origin
Race: Which categor	ry best describes your	race?									
☐ Black or African American	☐ White	☐ Asian Indian		Americ	can Indian or Al	aska Native	)	☐ Native Hawa	aiian	☐ Chi	nese
☐ Filipino☐ Guamanian or Chamorro	☐ Japanese☐ Other Pacific☐ Islander	☐ Korean ☐ Middle Eastern or No African		Vietnaı Two or	mese more races			☐ Other Asian☐ Some other☐		☐ Sar	moan oose not to disclose
	our preferred language										
☐ English☐ Bengali☐ Polish☐ Portuguese	☐ Spanish ☐ Yiddish ☐ Tagalog ☐ Hindi	☐ Chinese, Cantonese ☐ French ☐ Greek ☐ American Sign Langu	□ l: □ <i>F</i>	Italian Albania				☐ Russian ☐ Korean ☐ Urdu ☐ Choose not	to disclose	☐ Ara	nch Creole (Haitian Creole) Ibic tnamese
Dependent's Last N		First Name			M.I.	Date of Bi	irth (M	1M/DD/YY)	Relationship	)	Telephone (Daytime)
Mailing Address (If	different from above)					Email Add	dress				<u> </u>
Social Security Num	nber		PCP Nam	ne/ID I	Number		†Doi	nate Life Regist	ry 🗆 Yes 🗀	Skip fo	r now
	were you assigned at b										
☐ Male  Gender Identity: Wh	☐ Female at is your current gend	☐ Gender X ler identity:		Unknov	wn						
☐ Male ☐ Non-binary, Gende Pronouns: What are	☐ Female r X, Genderqueer, or third	☐ Transgender male/fe d gender ☐ Other:	male-to-mal Prefer to sel					☐ Transgende ☐ Choose not		-to-fem	ale (MTF)
☐ He/him	□ She/her	☐ They/them		Choose	e not to disclos	e					
Accessible format:	·	, ·									
☐ Not Applicable  Sexual Identity: Whi	ich of the following bes	☐ B-Braille		L -Larg	ge Print			☐ A-Audio CD		□ Ch	oose not to disclose
☐ Straight or heterosexual ☐ Choose not to disc	☐ Lesbian or gay	□ Bisexual		Queer, questic	pansexual, and oning	d/or		☐ Don't know			ner option not specified mething else)
Ethnicity: Are you o	f Hispanic, Latino/a or	Spanish Origin?									
☐ No, not of Hispanic Spanish origin ☐ Yes, Cuban	c, Latino/a, or	☐ Yes, Puerto Rican☐ Choose not to disclos		Yes, Do	ominican			☐ Yes, Mexica American C			s, Some Other Hispanic, ino/a, or Spanish Origin
	ry best describes your										
☐ Black or African American	☐ White	☐ Asian Indian		Americ	can Indian or Al	aska Native	)	☐ Native Hawa	aiian	☐ Chi	nese
☐ Filipino ☐ Guamanian or	☐ Japanese ☐ Other Pacific	☐ Korean ☐ Middle Eastern or No		Vietnaı Two or	mese more races			☐ Other Asian☐ Some other		□ Sar	noan oose not to disclose
Chamorro	Islander rour preferred language	African									
□ English	☐ Spanish	☐ Chinese, Cantonese		Chines	e, Mandarin			☐ Russian		☐ Fre	nch Creole (Haitian Creole)
☐ Bengali	☐ Yiddish	☐ French	□ l	Italian Albania				☐ Korean		☐ Ara	lbic
☐ Polish☐ Portuguese	□ Tagalog □ Hindi	☐ Greek ☐ American Sign Langu			an Language			☐ Choose not	to disclose	⊔ vie	tnamese

3. The Responsible Adult must complete the following child only information if applying for a <b>Child Only Contract</b> .  A child will be covered until the end of the year in which he/she becomes 21 years of age.											
Dependent 1 Last N			First Name		·	M.I.	Date of Birth (		Relationship		Telephone (Daytime)
Mailing Address (If	different from	above)						Email Address	3		
Sex (M/F/Non-Binary)   Social Security Number   PCP						Number		<sup>†</sup> Donate Life Re	egistry 🗆 Yes	Skip	for now
Birth Sex: What sex	were you assig	ned at birth?									
☐ Male  Gender Identity: Wh	☐ Female at is your curre		ender X <b>ntity:</b>		□ Unkno	own					
☐ Male ☐ Non-binary, Gende Pronouns: What are		, or third gende	ransgender male/fe er 🔲 Other:					☐ Transgende☐ Choose not	r female/ male- to disclose	to-fema	le (MTF)
☐ He/him  Accessible format:	☐ She/her		ney/them		☐ Choos	se not to disclos	se				
☐ Not Applicable  Sexual Identity: Whi	ch of the follow		Braille		□ L -Lar	rge Print		☐ A-Audio CD		☐ Cho	ose not to disclose
☐ Straight or heterosexual ☐ Choose not to disc	☐ Lesbian or g	Ū	sexual		-	r, pansexual, an ioning	d/or	□ Don't know			er option not specified nething else)
Ethnicity: Are you of		no/a or Spanis	sh Origin?								
☐ No, not of Hispanic Spanish origin ☐ Yes. Cuban		□ Ye	es, Puerto Rican		☐ Yes, D	Dominican		☐ Yes, Mexica American C	*		Some Other Hispanic, no/a, or Spanish Origin
Race: Which categor	ry best describe		loose not to disclos	SC							
☐ Black or African American	☐ White	□ As	sian Indian		☐ Ameri	ican Indian or A	laska Native	☐ Native Haw	aiian	☐ Chin	ese
☐ Filipino ☐ Guamanian or Chamorro	☐ Japanese ☐ Other Pacific	D M	orean iddle Eastern or No frican		☐ Vietna ☐ Two o	amese or more races		☐ Other Asiar☐ Some other		☐ Sam	oan ose not to disclose
Language: What is y			Tican								
☐ English☐ Bengali☐ Polish	☐ Spanish ☐ Yiddish	□ Cl □ Fr □ G			☐ Chine☐ Italiar☐ Alban			☐ Russian ☐ Korean ☐ Urdu		☐ Arab	nch Creole (Haitian Creole) Dic Dic
☐ Pottuguese	□ Tagalog □ Hindi		neek merican Sign Langu			Language		☐ Choose not	to disclose	□ viet	namese
Dependent 2 Last N	lame		First Name			M.I.	Date of Birth (	MM/DD/YY)	Relationship		Telephone (Daytime)
Mailing Address (If	different from	above)	1					Email Address	3		
Sex (M/F/Non-Binar	ry) Social S	Security Num	ber	PCP N	ame/ID	Number		<sup>†</sup> Donate Life Re	egistry 🗌 Yes	Skip	for now
Birth Sex: What sex	were you assig	ned at birth?									
☐ Male  Gender Identity: Wh	☐ Female at is your curre		ender X ntitv:		□ Unkno	own					
☐ Male ☐ Non-binary, Gende	☐ Female	□ Tı	ransgender male/fe					☐ Transgende	er female/ male- to disclose	to-fema	le (MTF)
Pronouns: What are											
☐ He/him Accessible format:	☐ She/her	□ TI	ney/them		☐ Choos	se not to disclos	se				
☐ Not Applicable  Sexual Identity: Whi	ch of the follow		Braille ribes you?		□ L -Lar	rge Print		☐ A-Audio CD		☐ Cho	ose not to disclose
☐ Straight or heterosexual ☐ Choose not to disc	☐ Lesbian or g lose	ay □ Bi	sexual		-	r, pansexual, an ioning	d/or	□ Don't know			er option not specified nething else)
Ethnicity: Are you o	f Hispanic, Latiı	no/a or Spanis	sh Origin?								
☐ No, not of Hispanic Spanish origin ☐ Yes, Cuban	, Latino/a, or		es, Puerto Rican noose not to disclos		☐ Yes, D	Dominican		☐ Yes, Mexica American C			Some Other Hispanic, no/a, or Spanish Origin
Race: Which categor	ry best describe	es your race?	sian Indian		□ Amori	ican Indian or A	lacka Nativa	☐ Native Haw	aijan	☐ Chin	020
American    Distriction Filipino	☐ Japanese		orean		☐ Vietna		ιωονα ινατίνε	☐ Other Asiar		□ Sam	
☐ Guamanian or Chamorro	Other Pacific	C □ M Af	iddle Eastern or No frican	orth		or more races		☐ Some other			ose not to disclose
Language: What is y											
☐ English☐ Bengali☐ Polish	☐ Spanish ☐ Yiddish ☐ Tagalog	□ Fr □ Gi	reek		□ Chine □ Italiar □ Alban			□ Russian □ Korean □ Urdu		☐ Fren☐ Arab	
☐ Portuguese	☐ Hindi	□ Aı	merican Sign Langu	iage	☐ Other	· Language		☐ Choose not	to disclose		

Dependent 3 Last Name				First Name			M.I.	Date of Birth (MM/DD/YY)		Relationship		-	Telephone (Daytime)	
Mailing Add	ress (If o	different from above)					I		Email Address	S				
Sex (M/F/Non-Binary) Social Security Number PC					PCP N	lame/ID	Number	*Donate Life Registry ☐ Yes ☐ Skip for now						
Birth Sex: W	hat sex v	were you assigned at b	oirth?		I				I					
☐ Male Gender Iden		☐ Female at is your current genc	☐ Ger der iden			□ Unkn	own							
		☐ Female X, Genderqueer, or thire your pronouns?			der male/female-to-male (FTM) □ Other: Prefer to self-describe					☐ Transgender female/ male-to-female (MTF)☐ Choose not to disclose				
☐ He/him  Accessible fe		□ She/her	☐ The	ey/them		☐ Choo	se not to disclo	se						
□ Not Applic			□ B-B	Proillo		☐ L -Laı	rgo Drint		☐ A-Audio CD	`		□ Choos	se not to disclose	
		ch of the following bes				L -Lai	ge riiii		A-Audio CL	,		LI CHOOS	se not to disclose	
☐ Straight or heterosexu ☐ Choose no	r ual ot to disclo	☐ Lesbian or gay	□ Bis	exual		☐ Queer, pansexual, and/or questioning							option not specified ething else)	
		Hispanic, Latino/a or							_			_		
☐ No, not of Spanish or ☐ Yes, Cubar	rigin	Latino/a, or		s, Puerto Rican oose not to disclo	ise	☐ Yes, [	Dominican		☐ Yes, Mexican, Mexican American Chicano/a		☐ Yes, Some Other Hispanic, Latino/a, or Spanish Origin			
Race: Which	category	y best describes your	race?											
☐ Black or Al American	frican	☐ White		an Indian		☐ American Indian or Alaska Native			☐ Native Hawaiian		☐ Chinese			
	☐ Filipino ☐ Japanese ☐ Korean ☐ Guamanian or ☐ Other Pacific ☐ Middle Eastern or No Chamorro ☐ Islander ☐ African ☐ Chamorro ☐ Other Pacific ☐ Middle Eastern or No Chamorro ☐ Other Pacific ☐ Middle Eastern or No Chamorro		orth	☐ Vietnamese ☐ Two or more races					☐ Samoan ☐ Choose not to disclose					
		our preferred language		Ican										
□ English       □ Spanish       □ Chinese, Cantone         □ Bengali       □ Yiddish       □ French         □ Polish       □ Tagalog       □ Greek         □ Portuguese       □ Hindi       □ American Sign La		nch é eek	□ Italia: □ Albar				☐ Russian ☐ Korean ☐ Urdu ☐ Choose not to disclose		☐ French Creole (Haitian Creole) ☐ Arabic ☐ Vietnamese					
4. Please	provid	e the following in	nform	ation for you	ır curi	rent or	prior heal	th benefits	plan (if any)					
Type of Plan	Name a	nd Address er		Telephone of Insurer	Number	r	Name of Policyholder		Policy I.D. Number			ive Date or Policy	Termination Date of Prior Policy	
Hospital				( )										
Medical				( )										
5. Medica	re Eligi	ibility												
If you are	applyin	g for individual co	verag	e, and if your	spous	se is eli	gible for Me	dicare, chec	k here					
6. Age 29	Covera	age												
The Age 29 Rider will extend dependent child coverage to the end of the month he/she becomes 30 years of age and is available for purchase. Please check the box if the dependent child(ren) require the purchase of the Age 29 Rider. Purchase Age 29 Rider   ———————————————————————————————————														
7. Change i	in Cove	rage												
If you are presently enrolled under a EmblemHealth Direct Payment Hospital/Medical Plan and want to change your enrollment status, please check the appropriate box below.														
I wish to cha	ange my	present coverage to:	□Indi	vidual Self/S	Spouse	☐ Self,	/Child □ Far	nily						
If this appli	ication	the (specify Plan s	lf/Spoi	use, or Self/C									ident child(ren)	

under 26 years of age. If this application is for child only coverage, as the responsible adult I have provided the child(ren) under 21 years of age.

If I have selected to purchase the Age 29 Rider I have included those dependent children under 29 years of age. I make this application on their behalf as well as my own.

When the application is processed, coverage will be effective only if payment is received in accordance with the invoice. I represent and understand that:

- A. On my enrollment date, my existing contract(s), if any, will be canceled.
- B. All statements and answers in this application are true to the best of my knowledge and belief.

NOTE: BEFORE DATING AND SIGNING THIS APPLICATION, PLEASE MAKE SURE YOU HAVE ANSWERED ALL THE QUESTIONS, AND HAVE CHECKED THE APPROPRIATE BOX FOR TYPE OF COVERAGE YOU DESIRE.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim concerning any materially false information, or conceals for the purposes 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 five thousand dollars and the stated value of the claim for each such violation.

Applicant's Signature (Do Not Print)		Date Signed
Applicant's Spouse's Signature (Do Not Print)	Necessary Only When Applying For Family Coverage	Date Signed
Responsible Adult's Signature (Do Not Print)	Necessary Only When Applying For Child Only Coverage	Date Signed

### **EmblemHealth Website**

Once coverage is effective, members have fast, convenient access to the latest claim status, eligibility, rate information, and benefits information, visit EmblemHealth's secure member website at emblemhealth.com. Available around the clock, the site offers provider listings, enables you to order ID cards, view an online Explanation of Benefits, access wellness information, and much more.

### **EmblemHealth Customer Service**

Language assistance services, free of charge, are available to you. Call 877-411-3625 (TTY: 711).

### **Select Care Network**

The EmblemHealth Select Care Network is a competitive, mid-tier network servicing members in 19 New York counties, consisting of Delaware, Dutchess, Orange, Putnam, Sullivan, Ulster, Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington, Broome, and Otsego.

### Millennium Network

The EmblemHealth Millennium Network is our most affordable network giving members in the five boroughs of New York City, Rockland County, Nassau County, Suffolk County, and Westchester County access to top providers and hospitals in the region.

### **Broker Commissions**

Premium for all individual Qualified Health Plan policies includes the cost of using a licensed insurance broker to assist individuals in selecting a plan. Insurance brokers are paid a fee of \$15 per contract per month.

	For EmblemHealth Of	ffice Use Only	
	(Initials)	(Initials)	
Date Application Issued			
Date Application Received			
Date Application Processed			
Date, Contract and Copy of Application Sent			
Type of Plan			
Group Number			
Benefit Set ID			
Effective Date			
Rep ID			