

I. SUBSCRIBER INFORMATION					
Last Name		First Name		M.I.	Social Security Number
Street Address		Apt.	City		State ZIP Code
<b>Were you ever a member of EmblemHealth?</b> <input type="checkbox"/> NO <input type="checkbox"/> YES If YES, member ID _____		<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner (DP)		<b>Birth Date:</b> Mo./Day/Yr.	
<b>Birth Sex: What sex were you assigned at birth?</b>					
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender X <input type="checkbox"/> Unknown					
<b>Gender Identity: What is your current gender identity:</b>					
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender male/female-to-male (FTM) <input type="checkbox"/> Transgender female/ male-to-female (MTF) <input type="checkbox"/> Non-binary, Gender X, Genderqueer, or third gender <input type="checkbox"/> Other: Prefer to self-describe <input type="checkbox"/> Choose not to disclose					
<b>Pronouns: What are your pronouns?</b>					
<input type="checkbox"/> He/him <input type="checkbox"/> She/her <input type="checkbox"/> They/them <input type="checkbox"/> Choose not to disclose					
<b>Accessible format:</b>					
<input type="checkbox"/> Not Applicable <input type="checkbox"/> B-Braille <input type="checkbox"/> L -Large Print <input type="checkbox"/> A-Audio CD <input type="checkbox"/> Choose not to disclose					
<b>Sexual Identity: Which of the following best describes you?</b>					
<input type="checkbox"/> Straight or heterosexual <input type="checkbox"/> Lesbian or gay <input type="checkbox"/> Bisexual <input type="checkbox"/> Queer, pansexual, and/or questioning <input type="checkbox"/> Don't know <input type="checkbox"/> Other option not specified (something else) <input type="checkbox"/> Choose not to disclose					
<b>Ethnicity: Are you of Hispanic, Latino/a or Spanish Origin?</b>					
<input type="checkbox"/> No, not of Hispanic, Latino/a, or Spanish origin <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Dominican <input type="checkbox"/> Yes, Mexican, Mexican American Chicano/a <input type="checkbox"/> Yes, Some Other Hispanic, Latino/a, or Spanish Origin <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Choose not to disclose					
<b>Race: Which category best describes your race?</b>					
<input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Asian Indian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian <input type="checkbox"/> Samoan <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Middle Eastern or North African <input type="checkbox"/> Two or more races <input type="checkbox"/> Some other race <input type="checkbox"/> Choose not to disclose					
<b>Language: What is your preferred language?</b>					
<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese, Cantonese <input type="checkbox"/> Chinese, Mandarin <input type="checkbox"/> Russian <input type="checkbox"/> French Creole (Haitian Creole) <input type="checkbox"/> Bengali <input type="checkbox"/> Yiddish <input type="checkbox"/> French <input type="checkbox"/> Italian <input type="checkbox"/> Korean <input type="checkbox"/> Arabic <input type="checkbox"/> Polish <input type="checkbox"/> Tagalog <input type="checkbox"/> Greek <input type="checkbox"/> Albanian <input type="checkbox"/> Urdu <input type="checkbox"/> Vietnamese <input type="checkbox"/> Portuguese <input type="checkbox"/> Hindi <input type="checkbox"/> American Sign Language <input type="checkbox"/> Other Language <input type="checkbox"/> Choose not to disclose					
Applicant's hours worked per week: <input type="checkbox"/> At least 20 hours <input type="checkbox"/> Less than 20 hours <input type="checkbox"/> COBRA <input type="checkbox"/> Retiree (see back of form**)				Home Tel. #: _____	
<b>Type of Coverage:</b> <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Employee & Spouse/DP <input type="checkbox"/> Employee & Child				Work Tel. #: _____	
Email Address: _____				Cell Tel. # (see back of form*): _____	
<b>Note:</b> If electing Young Adult Coverage, please submit a completed Young Adult Election Form.				<input type="checkbox"/> "Go Paperless" (see back of form)***	
<b>Primary Care Physician Name: (Not required for EPO/PPO members)</b>				ID Number: _____	
<b>OB/GYN Selection Name: (Optional)</b>				ID Number: _____	
<b>Are you covered by any other health insurance or Medicare?</b> <input type="checkbox"/> NO <input type="checkbox"/> YES If YES, indicate. Insurance Co. Name: _____ Insurance Co. Telephone #: _____ Policy #: _____			<b>Check One:</b> <input type="checkbox"/> New Enrollment <input type="checkbox"/> Reinstatement <input type="checkbox"/> Termination <input type="checkbox"/> Change	<b>Status:</b> <input type="checkbox"/> Add Dependent <input type="checkbox"/> Remove Dep. <input type="checkbox"/> Address Change <input type="checkbox"/> Name Change	<b>Transfer:</b> <input type="checkbox"/> To Another Carrier <input type="checkbox"/> EmblemHealth Group Change: From: _____ To: _____

**II. ENROLLMENT INFORMATION — IF YOU ARE ENROLLING YOUR SPOUSE/DP AND/OR CHILDREN, PLEASE LIST EACH ONE BELOW — SEE ELECTION OF COVERAGE FOR ELIGIBILITY**

Note: A birth/marriage certificate or 1040 Form will be required for spouse/dependents with different last name.

**Spouse/Dependent**

Dependent Last Name (if different)	First Name	M.I.	Social Security Number
*Donate Life Registry <input type="checkbox"/> Yes <input type="checkbox"/> Skip for now	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> DP <input type="checkbox"/> Child	Birth Date: Mo./Day/Yr.	
			<input checked="" type="checkbox"/> if Disabled <sup>1</sup>

Primary Care Physician Name/ID Number (Not required for EPO/PPO members)	OB/GYN Selection Name/ID Number (Optional)
--	--

**Birth Sex: What sex were you assigned at birth?**

Male       Female       Gender X       Unknown

**Gender Identity: What is your current gender identity:**

Male       Female       Transgender male/female-to-male (FTM)       Transgender female/ male-to-female (MTF)

Non-binary, Gender X, Genderqueer, or third gender       Other: Prefer to self-describe       Choose not to disclose

**Pronouns: What are your pronouns?**

He/him       She/her       They/them       Choose not to disclose

**Accessible format**

Not Applicable       B-Braille       L -Large Print       A-Audio CD       Choose not to disclose

**Sexual Identity: Which of the following best describes you?**

Straight or heterosexual       Lesbian or gay       Bisexual       Queer, pansexual, and/or questioning       Don't know       Other option not specified (something else)

Choose not to disclose

**Ethnicity**

No, not of Hispanic, Latino/a, or Spanish origin       Yes, Puerto Rican       Yes, Dominican       Yes, Mexican, Mexican American Chicano/a       Yes, Some Other Hispanic, Latino/a, or Spanish Origin

Yes, Cuban       Choose not to disclose

**Race: Which category best describes your race?**

Black or African American       White       Asian Indian       American Indian or Alaska Native       Native Hawaiian       Chinese

Filipino       Japanese       Korean       Vietnamese       Other Asian       Samoan

Guamanian or Chamorro       Other Pacific Islander       Middle Eastern or North African       Two or more races       Some other race       Choose not to disclose

**Language: What is your preferred language?**

English       Spanish       Chinese, Cantonese       Chinese, Mandarin       Russian       French Creole (Haitian Creole)

Bengali       Yiddish       French       Italian       Korean       Arabic

Polish       Tagalog       Greek       Albanian       Urdu       Vietnamese

Portuguese       Hindi       American Sign Language       Other Language       Choose not to disclose

Current Health Insurance Information:  
Carrier Name: \_\_\_\_\_ Coverage Begin Date: \_\_\_\_\_ Coverage End Date: \_\_\_\_\_

**Dependent**

Dependent Last Name (if different)	First Name	M.I.	Social Security Number
*Donate Life Registry <input type="checkbox"/> Yes <input type="checkbox"/> Skip for now	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> DP <input type="checkbox"/> Child	Birth Date: Mo./Day/Yr.	
			<input checked="" type="checkbox"/> if Disabled <sup>1</sup>

Primary Care Physician Name/ID Number (Not required for EPO/PPO members)	OB/GYN Selection Name/ID Number (Optional)
--	--

**Birth Sex: What sex were you assigned at birth?**

Male       Female       Gender X       Unknown

**Gender Identity: What is your current gender identity:**

Male       Female       Transgender male/female-to-male (FTM)       Transgender female/ male-to-female (MTF)

Non-binary, Gender X, Genderqueer, or third gender       Other: Prefer to self-describe       Choose not to disclose

**Pronouns: What are your pronouns?**

He/him       She/her       They/them       Choose not to disclose

**Accessible format**

Not Applicable       B-Braille       L -Large Print       A-Audio CD       Choose not to disclose

**Sexual Identity: Which of the following best describes you?**

Straight or heterosexual       Lesbian or gay       Bisexual       Queer, pansexual, and/or questioning       Don't know       Other option not specified (something else)

Choose not to disclose

**Ethnicity**

No, not of Hispanic, Latino/a, or Spanish origin       Yes, Puerto Rican       Yes, Dominican       Yes, Mexican, Mexican American Chicano/a       Yes, Some Other Hispanic, Latino/a, or Spanish Origin

Yes, Cuban       Choose not to disclose

**Race: Which category best describes your race?**

Black or African American       White       Asian Indian       American Indian or Alaska Native       Native Hawaiian       Chinese

Filipino       Japanese       Korean       Vietnamese       Other Asian       Samoan

Guamanian or Chamorro       Other Pacific Islander       Middle Eastern or North African       Two or more races       Some other race       Choose not to disclose

**Language: What is your preferred language?**

English       Spanish       Chinese, Cantonese       Chinese, Mandarin       Russian       French Creole (Haitian Creole)

Bengali       Yiddish       French       Italian       Korean       Arabic

Polish       Tagalog       Greek       Albanian       Urdu       Vietnamese

Portuguese       Hindi       American Sign Language       Other Language       Choose not to disclose

Current Health Insurance Information:  
Carrier Name: \_\_\_\_\_ Coverage Begin Date: \_\_\_\_\_ Coverage End Date: \_\_\_\_\_

**Dependent 2**

Dependent Last Name (if different)	First Name	M.I.	Social Security Number
*Donate Life Registry <input type="checkbox"/> Yes <input type="checkbox"/> Skip for now	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> DP <input type="checkbox"/> Child		Birth Date: Mo./Day/Yr.
<b>Primary Care Physician Name/ID Number (Not required for EPO/PPO members)</b>		<b>OB/GYN Selection Name/ID Number (Optional)</b>	

**Birth Sex: What sex were you assigned at birth?**

Male       Female       Gender X       Unknown

**Gender Identity: What is your current gender identity:**

Male       Female       Transgender male/female-to-male (FTM)       Transgender female/ male-to-female (MTF)

Non-binary, Gender X, Genderqueer, or third gender       Other: Prefer to self-describe       Choose not to disclose

**Pronouns: What are your pronouns?**

He/him       She/her       They/them       Choose not to disclose

**Accessible format**

Not Applicable       B-Braille       L -Large Print       A-Audio CD       Choose not to disclose

**Sexual Identity: Which of the following best describes you?**

Straight or heterosexual       Lesbian or gay       Bisexual       Queer, pansexual, and/or questioning       Don't know       Other option not specified (something else)

Choose not to disclose

**Ethnicity**

No, not of Hispanic, Latino/a, or Spanish origin       Yes, Puerto Rican       Yes, Dominican       Yes, Mexican, Mexican American Chicano/a       Yes, Some Other Hispanic, Latino/a, or Spanish Origin

Yes, Cuban       Choose not to disclose

**Race: Which category best describes your race?**

Black or African American       White       Asian Indian       American Indian or Alaska Native       Native Hawaiian       Chinese

Filipino       Japanese       Korean       Vietnamese       Other Asian       Samoan

Guamanian or Chamorro       Other Pacific Islander       Middle Eastern or North African       Two or more races       Some other race       Choose not to disclose

**Language: What is your preferred language?**

English       Spanish       Chinese, Cantonese       Chinese, Mandarin       Russian       French Creole (Haitian Creole)

Bengali       Yiddish       French       Italian       Korean       Arabic

Polish       Tagalog       Greek       Albanian       Urdu       Vietnamese

Portuguese       Hindi       American Sign Language       Other Language       Choose not to disclose

Current Health Insurance Information:  
Carrier Name: \_\_\_\_\_ Coverage Begin Date: \_\_\_\_\_ Coverage End Date: \_\_\_\_\_

For dependent adult children incapable of self-sustaining employment, please see Section A on the back side of this form to check the appropriate "Add Dependent" box, and follow the instruction for required documentation.

**Your signature is required to process this form. Your signature attests that you have read the reverse side 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 five thousand dollars and the stated value of the claim for each such violation.

**Applicant must sign here:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**III. EMPLOYER INFORMATION – THIS SECTION TO BE COMPLETED BY EMPLOYER/CONTRACTOR GROUP**

Name of Group:	Group Number:	Sub Group ID _____ Class ID _____ Plan ID _____
If you selected a small group metal plan, please indicate which plan you are selecting : _____		
<input type="checkbox"/> Health Insurance Plan of Greater New York (HIP) <input type="checkbox"/> EmblemHealth Plan, Inc. <input type="checkbox"/> EmblemHealth Insurance Company Plan Name: _____		
Requested Effective Date: Medical: _____ Dental: _____	Hire Date:	Waiting Period: _____ Date Submitted:
Approved By: (Group Plan Administrator)		
Instructions to Benefit Administrators or Group Representatives: For groups with 100 or fewer full-time equivalent eligible employees, you MUST complete Section A on the reverse side of this form. Required documentation MUST be attached to this Transaction Form to be processed.		

**IMPORTANT INFORMATION**

- The subscriber must complete sections I and II. The group plan administrator must complete section III, and if for a small group (100 or fewer full-time equivalent eligible employees) provide all necessary documentation.
- All transactions are subject to EmblemHealth's retroactive enrollment period – members must be enrolled within 60 days (for small groups) or 90 days (for large groups) from the Qualifying Event.
- As part of New York State's "Age 29" law, eligible young adults through age 29 may obtain coverage through a parent's group policy.
- Failure to complete any part of this form (e.g., group number, reason for submission, certificate number, signature, etc.) will require EmblemHealth to return this transaction form to the employer group plan administrator and may delay the requested effective date of coverage.
- Return the completed Transaction Form along with any required documentation to: Membership, PO Box 2820, New York, NY 10116-2820.

Get more information at [emblemhealth.com](http://emblemhealth.com).

**HSA**

An HSA is a tax-free fund that can be used to pay for qualified medical and/or pharmacy expenses. EmblemHealth has partnered with Health Equity to provide this service for our customers with a high deductible health plan. Benefits include a full integration of enrollment and claim payment for only qualified high deductible health plans. Would you like to open employee HSA accounts with Health Equity?  YES  NO

**HRA – Large Group Only**

Health Reimbursement Arrangements (HRAs) are arrangements that allow an employer to reimburse for medical expenses paid by participating employees. HRAs reimburse only those items (copays, coinsurance, deductibles, prescription drugs, and services) agreed to by the employer which are not covered by the company's selected standard insurance plan. EmblemHealth has partnered with Health Equity to provide this service for our customers. Benefits include a full integration of enrollment and claim payment for only qualified high deductible health plans. Would you like to open an HRA account with Health Equity?  YES  NO

**SECTION A** (To be completed by Benefits Administrator)

<b>ACTION Check (✓)One</b>	<b>Qualifying Event</b>	<b>Documentation Required</b>
<input type="checkbox"/> Add Subscriber	New Hire or Change in Plan	For eligible employees who work at least 20 hours per week, provide a recent Copy of NYS-45 showing this subscriber as an employee or provide copy of payroll documentation reflecting the date, employee's name and Social Security #, or the employee's current-year W-4 Form.
<input type="checkbox"/> Add Spouse	Marriage	<b>If last name is different</b> <input type="checkbox"/> Marriage Certificate <input type="checkbox"/> 1040 Form
<input type="checkbox"/> Add Dependent	Birth or Adoption	<b>If last name is different</b> <input type="checkbox"/> Birth Certificate <input type="checkbox"/> Formal Adoption Papers <input type="checkbox"/> Court-Approved Guardianship Papers
<input type="checkbox"/> Add Young Adult	Young Adult Coverage	Young Adult Election Form
<input type="checkbox"/> Add Dependent	Dependent Adult Child Incapable of Self-Sustaining Employment	Disability Status Request Form
<input type="checkbox"/> Add Spouse <input type="checkbox"/> Add Dependent	Loss of Coverage	Certificate of Creditable Coverage
<input type="checkbox"/> Add Domestic Partner	Domestic Partnership	Declaration of Cohabitation & Financial Interdependence Form

**Donate Life Registry\***

- You must select an option for yourself and any dependents applying for coverage
- Donate Life Registry for organ, eye, and tissue donation
- Dependents must be at least 16 years old in order to opt in for Donate Life Registry

**Note: No exceptions to our retroactive enrollment period will be allowed. Small group members must be enrolled within 30 days from the Qualifying Event/next billing date (or within 90 days for large group members).**

\* I understand that the phone number(s) I provided on this form may be used by EmblemHealth or any of its contracted parties to contact me about my account, my health benefit plan or related programs, or services provided to me.

\*\*Retiree option is applicable for large groups only.

\*\*\*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.

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