

Transaction Form for Group Accounts

I. SUBSCRIBER IN	FORMATION											
Last Name			First Nam	ne			1	M.I.	Social Sec	urity Nu	ımber	
Street Address		Apt.	Apt. City					State			ZIP Code	
Were you ever a me If YES, member ID	mber of EmblemHealth	? NO YES	Marital S ☐ Single	Marital Status: ☐ Single ☐ Married ☐ Domestic Partner			Birth Da			e: Mo./D	ay/Yr.	
Birth Sex: What sex were you assigned at birth?												
☐ Male	☐ Female	☐ Gender X		☐ Unknov	vn							
Gender Identity: WI	hat is your current geno	der identity:										
☐ Male ☐ Female ☐ Transgender mal			r male/female-	lle/female-to-male (FTM)			□ Transgender female/ male-to-female (MTF)					
☐ Non-binary, Gend	er X, Genderqueer, or thi	ird gender 🗆 🗆	Other: Prefer	her: Prefer to self-describe				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 -Larg	e Print		☐ A-Audio (CD Choose not to disclo			: to disclose	
Sexual Identity: Wh	ich of the following bes	st describes you	?									
☐ Straight or heterosexual	□ Lesbian or gay	□ Bisexual		□ Queer, questio	pansexual, and/o	or [□ Don't kno	OW	w			
☐ Choose not to dis												
	of Hispanic, Latino/a or											
☐ No, not of Hispanic, Latino/a, or ☐ Yes, Puerto Rica Spanish origin			América			,	ican, Mexican					
☐ Yes, Cuban		☐ Choose not	to disclose									
Race: Which category best describes your race?												
☐ Black or African American	☐ White	□ Asian Indian		Native	an Indian or Alas							
Filipino	☐ Japanese	☐ Korean		□ Vietnar			□ Other Asi			□ San		
□ Guamanian or □ Other Pacific □ Middle Eastern or North Chamorro Islander African			ern or North	☐ Two or more races ☐ Some other			ner ra	race Choose not to disclose				
	your preferred language											
☐ English	☐ Spanish ☐ Chinese, Cantonese		☐ Chinese, Mandarin			☐ Russian			☐ French Creole (Haitian Creole)		ole (Haitian Creole)	
□ Bengali	☐ Yiddish	☐ French		□ Italian			☐ Korean			☐ Arabic		
☐ Polish	☐ Tagalog	☐ Greek		□ Albanian □ Urdu				□ Vietnamese			Э	
☐ Portuguese	☐ Hindi	☐ American Si		□ Other L			☐ Choose n	ot to	disclose			
	rked per week: At leas						of form**)		-			
Type of Coverage: ☐ Individual ☐ Family ☐ Employee 8 Email Address: ☐ Employee 8			Employee & S _l	ouse/DP LI Employee & Child				Work Tel. #: Cell Tel. # (see back of form*):				
Note: If electing Young Adult Coverage, please submit a completed Yo				ung Adult Election Form.					Go Paperless" (see back of form)***			
Primary Care Physician Name: (Not required for EPO/PPO mem								ID Number:				
	-											
OB/GYN Selection Name: (Optional) ID Number:												
Are you covered by a	ny other health insurance	or Medicare?	NO □YES If	YES, indicate		Check			atus:	$\overline{}$	Transf	
Insurance Co. Name: New Enrollment Add Dependent To Another Carrier Remove Dep. EmblemHealth Group							blemHealth Group					
Insurance Co. Telephone #: Type of Coverage			ıge:		☐ Termination☐ Change			Address Change Change: Name Change		ange: m:		
Policy #:			Effective Date:								To:	

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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 ☐ Yes ☐ Skip for now				Relationship ☐ Spouse ☐ DP ☐ Child			Birth	Date: Mo	/Day/Yr.	√ if Disabled¹
Primary Care Physician Name/ID Number (Not required for EPO/				bers)	OB/GYN Select	tion Name/ID N	Numbe	r (Optiona	1)	
Birth Sex: What sex v	vere you assigned at b	irth?								
☐ Male	☐ Female	☐ Gender X		☐ Unknown						
Gender Identity: Wha	it is your current gend	ler identity:								
☐ Male ☐ Female ☐ Transgender ma ☐ Non-binary, Gender X, Genderqueer, or third gender ☐ Or Pronouns: What are your pronouns?				-to-male (FTM) er to self-describ	e	□ Transgend □ Choose no			-to-female (MTF)	
☐ He/him	☐ She/her	☐ They/them		☐ Choose not	to disclose					
Accessible format										
☐ Not Applicable		☐ B-Braille		□ L -Large Pri	nt	☐ A-Audio C	CD			se
Sexual Identity: Which	ch of the following bes	t describes you?								
☐ Straight or heterosexual ☐ Choose not to discl Ethnicity	heterosexual Choose not to disclose			□ Queer, pans questioning		□ Don't kno	W	☐ Other option not specified (something else)		ecified
☐ No, not of Hispanic, Latino/a, ☐ Yes, Puerto Rican or Spanish origin ☐ Choose not to disc		•		ican	☐ Yes, Mexican, Mexican American Chicano/a			☐ Yes, Some Other Hispanic, Latino/a, or Spanish Origin		
	y best describes your		SCIUSE							
☐ Black or African American	☐ White	☐ Asian Indian		☐ American Indian or Alaska Native		☐ Native Hawaiian			☐ Chinese	
☐ Filipino ☐ Guamanian or Chamorro	☐ Japanese ☐ Other Pacific Islander	☐ Korean ☐ Middle Eastern or North African		☐ Vietnamese☐ Two or more races		□ Other Asian □ Some other race		☐ Samoan ☐ Choose not to disclose		
Language: What is yo	our preferred language		000	☐ Chinese, Ma	ndarin	☐ Russian			☐ French Creole (Haitia	an Craala)
☐ Bengali ☐ Polish ☐ Portuguese	☐ Yiddish ☐ Tagalog ☐ Hindi	☐ Chinese, Cantonese ☐ French ☐ Greek ☐ American Sign Language		□ Italian □ Albanian		☐ Korean ☐ Urdu ☐ Choose not to disclose		sclose	☐ Arabic ☐ Vietnamese	
Current Health Insuran	ce Information:									
Carrier Name: Coverage Begin Date: Coverage End Date:										
Dependent										
Dependent Last Name (if different)			First Nar	irst Name			M.I.	. Social Security Number		
[†] Donate Life Registry	☐ Yes ☐ Skip for now		Relation	nship \square Spouse	□DP□Child		Birth	Date: Mo	/Day/Yr.	√ if Disabled¹
Primary Care Physician Name/ID Number (Not required for EPO/PPO members) OB/GYN Selection Name/ID Number (Optional)										
Birth Sex: What sex v	vere you assigned at b	oirth?								
☐ Male	☐ Female	☐ Gender X		☐ Unknown						
Gender Identity: What is your current gender identity:										
☐ Male ☐ Non-binary, Gender Pronouns: What are y	to-male (FTM)									
☐ He/him Accessible format	☐ She/her	☐ They/them		☐ Choose not	to disclose					
☐ Not Applicable		☐ B-Braille		☐ L -Large Print ☐ A-Audio			udio CD			se
	h of the following has					_ // // // // /	-		55500 Hot to distil	
Sexual Identity: Which of the following best describes you? ☐ Straight or ☐ Lesbian or gay ☐ Bisexual heterosexual ☐ Choose not to disclose			☐ Queer, pans questioning		□ Don't kno	☐ Don't know ☐ Other option not spec (something else)			ecified	

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Ethnicity										
or Spanish origin □ Yes, Cuban	. •			☐ 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 African	☐ White	☐ Asian Indian		☐ American Indian or		☐ Native Ha	waiian		☐ Chinese	
American □ Filipino	☐ Japanese	☐ Korean		Alaska Native		☐ Other Asi	an.		☐ Samoan	
☐ Guamanian or	☐ Other Pacific	☐ Middle Eastern o	ır	☐ Vietnamese ☐ Two or more races		☐ Some oth		ı	☐ Choose not to disclose	
Chamorro Islander North African					0 14000	- come other race				
Language: What is yo	ur preferred language	e?								
☐ English	☐ Spanish	☐ Spanish ☐ Chinese, Cantonese			☐ Chinese, Mandarin				☐ French Creole (Haitian Creole)	
□ Bengali	☐ Yiddish	☐ French		☐ Italian		☐ Korean			☐ Arabic	
☐ Polish	☐ Tagalog	☐ Greek		☐ Albanian	1000	□ Urdu		iaalaaa	☐ Vietnamese	
	□ Portuguese □ Hindi □ American Sign Language □ Other Language □ Choose not to disclose									
Current Health Insuran Carrier Name:		Coverage Begin Da	te:		Coverage End	d Date:			_	
Dependent 2										
Dependent Last Name	(if different)		First Nar	mo			МТ	Social S	nourity Number	
Dependent Last Name	(ii dillerenc)		FIISLINAI	ne		M.I. Social S			Security Number	
[†] Donate Life Registry	☐ Yes ☐ Skip for now	,	Relation	nship 🗆 Spouse	☐ DP ☐ Child		Birth	Date: Mo.	e: Mo./Day/Yr.	
Primary Care Physicia	an Name/ID Number (Not required for EPO/	PPO memi	bers)	OB/GYN Select	ion Name/ID I	Numbe	r (Optiona	D	
				,					,	
Birth Sex: What sex w	vere you assigned at b	oirth?								
☐ Male	☐ Female	☐ Gender X		☐ Unknown						
Gender Identity: Wha	it is your current geno	ler identity:								
☐ Male	☐ Female	☐ Transgender ma	•						e-to-female (MTF)	
☐ Non-binary, Gender Pronouns: What are y		rd gender	ther: Prefe	er to self-describ	e	☐ Choose n	ot to d	sclose		
☐ He/him	☐ 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 Lesbian or gay Bisexual Queer, pansexual, and/or Don't know Other option not specified										
heterosexual				questioning		□ DOII t KIIO	vv		(something else)	neu
□ Choose not to disclose										
Ethnicity										
□ No, not of Hispanic, Latino/a, □ Yes, Puerto			n	☐ Yes, Domini	can	☐ Yes, Mexi			☐ Yes, Some Other Hispa	
or Spanish origin □ Yes, Cuban		☐ Choose not to di	ccloso			American	Chicar	10/a	Latino/a, or Spanish Or	rigin
Race: Which category	best describes vour		301036							
□ Black or African □ White □ Asian Indian □ American Indian or □ Native Hawaiian □ Chinese										
American				Alaska Nativ						
☐ Filipino	·						☐ Other Asian ☐ Some other race		□ Samoan	
☐ Guamanian or ☐ Other Pacific ☐ Middle Eastern or Chamorro Islander North African				☐ Two or more	☐ Some oth	er race	!	☐ Choose not to disclose		
Language: What is yo										
☐ English	☐ Spanish	☐ Chinese, Canton	ese	☐ Chinese, Ma	ndarin	☐ Russian			☐ French Creole (Haitian	Creole)
□ Bengali				☐ Italian ´		☐ Korean			☐ Arabic	
☐ Polish	☐ Tagalog	☐ Greek ☐ Albanian ☐ Urdu ☐ Vietnamese					☐ Vietnamese			
☐ Portuguese	☐ Hindi	☐ American Sign L	anguage	☐ Other Langu	ıage	☐ Choose n	ot to d	sclose		
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 nstruction for required documentation.										
Your signature is requ		rm Vour eignature	ttoete th	at vou have rece	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 h	iere:						_ Dat	e:		

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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 :						
Health Insurance Plan of Greater New York (HIP) EmblemHealth Plan, Inc. 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 grouthis form. Required documentation MUST be attached to this Transaction		nt eligible employees, you MUST co	mplete Section A on the reverse side of				

IMPORTANT INFORMATION

- 1. 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.
- 2. 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.
- 3. 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.
- 4. 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.
- 5. 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.

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?

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?

SECTION A (To be completed by Benefits Administrator)

ACTION Check (✔)One	Qualifying Event	Documentation Required
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.
Add Spouse	Marriage	If last name is different ☐ Marriage Certificate ☐ 1040 Form
Add Dependent	Birth or Adoption	If last name is different ☐ Birth Certificate ☐ Formal Adoption Papers ☐ Court-Approved Guardianship Papers
Add Young Adult	Young Adult Coverage	Young Adult Election Form
Add Dependent	Dependent Adult Child Incapable of Self- Sustaining Employment	Disability Status Request Form
Add Spouse Add Dependent	Loss of Coverage	Certificate of Creditable Coverage
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.

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