EmblemHealth®

# 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, and Self/Child) to your status as indicated below:

**Individual**

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

**Self/Spouse, Self/Child, and Family**

- If you are married, or if you are married with eligible children. If you are married and your spouse is eligible for Medicare, and you're covering one or more children 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 eligible children.
- If you have one or more eligible 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 biological 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. |
|---|---|---|

**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.**

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.



PRINT RESET

**PRINT IN INK**

**Type of contract:** ☐ Individual ☐ Individual & Spouse ☐ Parent & Child(ren) ☐ Family (Individual/Spouse & Child(ren) ☐ Child Only

**Plan selection:** Requested plan start date: _____

**Please specify plan:**

Plans listed below are part of our Select Care Network.

☐ Select Care Platinum D ☐ Select Care Bronze D
☐ Select Care Gold D ☐ Select Care Catastrophic D
☐ Select Care Silver D

Plans listed below are part of our Millennium Network.

☐ Millennium Platinum D ☐ Millennium Silver D
☐ Millennium Gold D ☐ Millennium Bronze D

- All enrollees/members requesting enrollment after the end of open enrollment must have a qualifying life event in order to be eligible for health insurance coverage.
- Please check here if you are you applying after the end of open enrollment with a qualifying life event. ☐
- Has your employer contributed money to your EmblemHealth individual health plan premium through an individual coverage Health Reimbursement Arrangement (HRA)? ☐ Yes ☐ No

Donate Life Registry

- You must select an option for yourself and any eligible family members applying for coverage.
- Eligible family members must be at least 16 years old to opt in to the Donate Life Registry.
- Donate Life Registry for organ, eye, and tissue donation.

**1. Please complete the following information for the subscriber.**

| Subscriber's Last Name | First Name | M.I. | Date of Birth (MM/DD/YY) | Social Security Number |
|---|---|---|---|---|
| | | | | |

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

☐ Male ☐ Female ☐ Gender X ☐ Unknown

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

☐ 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: Are you of Hispanic, Latino/a or Spanish Origin?**

☐ No, not of Hispanic, Latino/a, or Spanish origin ☐ Yes, Puerto Rican ☐ Yes, Dominican ☐ Yes, Mexican or 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 ☐ 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

| Home Address (P.O. Box is not acceptable) | Telephone Numbers<br>Cell: Home: Work: | | |
|---|---|---|---|
| City | County | State | ZIP Code |
| Mailing Address (If different from Home Address) | | Donate Life Registry ☐ Yes ☐ Skip for now | |
| City | County | State | ZIP Code |
| Applicant Email Address | Primary Care Provider (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) in the Claims section of the EmblemHealth member portal, myEmblemHealth. 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.

**2. Please complete the following spouse and/or eligible child(ren) information if applying for a Family Contract. An eligible child will be covered until the end of the month in which he/she becomes 26 years of age.**

| Spouse Last Name | First Name | M.I. | Date of Birth (MM/DD/YY) | Relationship | Telephone (daytime) |
|---|---|---|---|---|---|
| | | | | | |

| Mailing Address (If different from above) | Email Address |
|---|---|
| | |

| Social Security Number | PCP Name/ID Number | Donate Life Registry ☐ Yes ☐ Skip for now |
|---|---|---|
| | | |

**Birth Sex: What sex was spouse assigned at birth?**

☐ Male ☐ Female ☐ Gender X ☐ Unknown

**Gender Identity: What is your spouse's 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 spouse's 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 your spouse?**

☐ 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: Is your spouse of Hispanic, Latino/a or Spanish Origin?**

☐ 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 spouse's 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 ☐ Other race ☐ Choose not to disclose

**Language: What is your preferred spouse's 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

| Eligible Family Member's Last Name | First Name | M.I. | Date of Birth (MM/DD/YY) | Relationship | Telephone (daytime) |
|---|---|---|---|---|---|
| | | | | | |

| Mailing Address (If different from above) | Email Address |
|---|---|
| | |

| Social Security Number | PCP Name/ID Number | Donate Life Registry ☐ Yes ☐ Skip for now |
|---|---|---|
| | | |

**Birth Sex: What sex was your eligible family member assigned at birth?**

☐ Male ☐ Female ☐ Gender X ☐ Unknown

**Gender Identity: What is your eligible family member's 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 eligible family member's 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 your eligible family member?**

☐ 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: Is your eligible family member of Hispanic, Latino/a or Spanish Origin?**

☐ 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 eligible family member's 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 ☐ Other race ☐ Choose not to disclose

**Language: What is your eligible family member's 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

**3. The responsible adult must complete the following child only information if applying for a Child Only Contract. An eligible child will be covered until the end of the year in which they become 21 years of age.**

| Child 1 Last Name | First Name | M.I. | Date of Birth (MM/DD/YY) | Relationship | Telephone (daytime) |
|---|---|---|---|---|---|
| | | | | | |

| Mailing Address (If different from above) | Email Address |
|---|---|
| | |

| Sex (M/F/Non-Binary) | Social Security Number | PCP Name/ID Number | Donate Life Registry ☐ Yes ☐ Skip for now |
|---|---|---|---|
| | | | |

**Birth Sex: What sex was your child assigned at birth?**

☐ Male ☐ Female ☐ Gender X ☐ Unknown

**Gender Identity: What is your child's 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 child's 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 your child?**

☐ 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: Is your child of Hispanic, Latino/a or Spanish Origin?**

☐ No, not of Hispanic, Latino/a, or Spanish origin ☐ Yes, Puerto Rican ☐ Yes, Dominican ☐ Yes, Mexican or 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 child's 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 ☐ Other race ☐ Choose not to disclose

**Language: What is your child's 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

| Child 2 Last Name | First Name | M.I. | Date of Birth (MM/DD/YY) | Relationship | Telephone (daytime) |
|---|---|---|---|---|---|
| | | | | | |

| Mailing Address (If different from above) | Email Address |
|---|---|
| | |

| Sex (M/F/Non-Binary) | Social Security Number | PCP Name/ID Number | Donate Life Registry ☐ Yes ☐ Skip for now |
|---|---|---|---|
| | | | |

**Birth Sex: What sex was your child assigned at birth?**

☐ Male ☐ Female ☐ Gender X ☐ Unknown

**Gender Identity: What is your child's 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 child's 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 your child?**

☐ 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: Is your child of Hispanic, Latino/a or Spanish Origin?**

☐ No, not of Hispanic, Latino/a, or Spanish origin ☐ Yes, Puerto Rican ☐ Yes, Dominican ☐ Yes, Mexican or 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 child's 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 ☐ Other race ☐ Choose not to disclose

**Language: What is your child's 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

| Child 3 Last Name | First Name | M.I. | Date of Birth (MM/DD/YY) | Relationship | Telephone (daytime) |
|---|---|---|---|---|---|
| | | | | | |

| Mailing Address (If different from above) | Email Address |
|---|---|
| | |

| Sex (M/F/Non-Binary) | Social Security Number | PCP Name/ID Number | Donate Life Registry ☐ Yes ☐ Skip for now |
|---|---|---|---|
| | | | |

**Birth Sex: What sex was your child assigned at birth?**

☐ Male ☐ Female ☐ Gender X ☐ Unknown

**Gender Identity: What is your child's 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 child's 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 your child?**

☐ 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: Is your child of Hispanic, Latino/a or Spanish Origin?**

☐ No, not of Hispanic, Latino/a, or Spanish origin ☐ Yes, Puerto Rican ☐ Yes, Dominican ☐ Yes, Mexican or 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 child's 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 ☐ Other race ☐ Choose not to disclose

**Language: What is your child's 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

## 4. Please provide the following information for your current or prior health benefits plan (if any).

| Type of Plan | Name and Address of Insurer | Telephone Number of Insurer | Name of Policyholder | Policy ID Number | Effective Date of Prior Policy | Termination Date of Prior Policy |
|---|---|---|---|---|---|---|
| Hospital | | | | | | |
| Medical | | | | | | |

## 5. Medicare Eligibility

If you are applying for individual coverage, and if your spouse is eligible for Medicare, check here. ☐

## 6. Age 29 Coverage

The Age 29 Rider will extend eligible child coverage to the end of the month they become 30 years of age and is available for purchase. Please check the box if the eligible child(ren) require the purchase of the Age 29 Rider. Purchase Age 29 Rider ☐

## 7. Change in Coverage

**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 change my present coverage to: ☐ Individual ☐ Self/Spouse ☐ Self/Child ☐ Family

I hereby apply for the (specify plan selection) _____

If this application is for family, self/spouse, or self/child coverage, I have provided the names of my spouse and/or eligible child(ren) under 26 years of age. If this application is for child only coverage, as the responsible adult, I have provided the names of my child(ren) under 21 years of age. If I have selected to purchase the Age 29 Rider and I have included those eligible 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 $5,000 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) Date Signed
Necessary Only When Applying For Family Coverage

Responsible Adult's Signature (do not print) Date Signed
Necessary Only When Applying For Child Only Coverage

**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. The site offers doctor and hospital listings, lets you order ID cards, view online Explanations of Benefits, find 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 services members in 19 New York counties, including 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 access to top providers and hospitals in the five boroughs of New York City, Rockland County, Nassau County, Suffolk County, and Westchester County.

**For EmblemHealth Office 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 | _____ | _____ |

EmblemHealth®

**Notice of Availability of Language Assistance Services and Auxiliary Aids and Services**

**English** ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call **877-411-3625** (TTY: **711**) or speak to your provider.

**Español (Spanish)** ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al **877-411-3625** (TTY: **711**) o hable con su proveedor.

**中文 (Simplified Chinese)** 注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 **877-411-3625**（文本电话：**711**）或咨询您的服务提供商。

**РУССКИЙ (Russian)** ВНИМАНИЕ: Если вы говорите на русском, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону **877-411-3625** (TTY: **711**) или обратитесь к своему поставщику услуг.

**Kreyòl Ayisyen (Haitian Creole)** ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nan **877-411-3625** (TTY: **711**) oswa pale avèk founisè w la.

**한국어 (Korean)** 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. **877-411-3625** (TTY: **711**) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

**Italiano (Italian)** ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l' **877-411-3625** (tty: **711**) o parla con il tuo fornitore.

(**Yiddish**) **יידיש** נאטיץ: אויב איר רעדט יידיש, שפראך הילף סערוויסעס זענען בארעכטיגט פאר דיר פריי. צונעמען אַידס און באַדינונגס פֿאַר פֿראַוויידינג אינפֿאָרמאַציע אין צוטריטלעך פֿאָרמאַטירונגען זענען אויך בנימצא פריי. רופן **877-411-3625** (TTY: **711**) אָדער רעדן מיט דיין טרעגער.

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**POLSKI (Polish)** UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer **877-411-3625** (TTY: **711**) lub porozmawiaj ze swoim dostawcą.

**العربية (Arabic)**

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم **877-411-3625** (**711**) أو تحدث إلى مقدم الخدمة.

**Français (French)** ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le **877-411-3625** (TTY: **711**) ou parlez à votre fournisseur.

**اردو (Urdu)**

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ (TTY: **711**) **877-411-3625** پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔

**Tagalog (Tagalog)** PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa **877-411-3625** (TTY: **711**) o makipag-usap sa iyong provider.

**Ελληνικά (Greek)** ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες υποστήριξης στη συγκεκριμένη γλώσσα. Διατίθενται δωρεάν κατάλληλα βοηθήματα και υπηρεσίες για παροχή πληροφοριών σε προσβάσιμες μορφές. Καλέστε το **877-411-3625** (TTY: **711**) ή απευθυνθείτε στον πάροχό σας.

**SHQIP (Albanian)** VINI RE: Nëse flisni shqip, shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi **877-411-3625** (TTY: **711**) ose bisedoni me ofruesin tuaj të shërbimit.

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Discrimination is Against the Law

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## EmblemHealth:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
    - Qualified sign language interpreters.
    - Written information in other formats (large print, audio, accessible electronic formats, and other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
    - Qualified interpreters.
    - Information written in other languages.

## If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services contact the Civil Rights Coordinator by calling Customer Service at **877-411-3625** (TTY: **711**).

If you believe that EmblemHealth has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Coordinator by writing to the EmblemHealth Grievance and Appeals Department, P.O. Box 2844, New York, NY 10116-2844; faxing them at **212-510-5320**; or calling Customer Service at **877-411-3625**. (Dial **711** for TTY services.) You can file a grievance in person, by mail, by fax, or through your secure member portal. If you need help filing a grievance, EmblemHealth's Grievance and Appeals Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail or phone at: **U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201**; **800-368-1019** (TTY: **800-537-7697**).

Complaint forms are available at **hhs.gov/ocr/office/file/index.html**.

This notice is available on EmblemHealth's website at **emblemhealth.com/legal/nondiscrimination**.