EmblemHealth®

Transaction Form for Group Accounts

I. SUBSCRIBER INFORMATION

Last Name	First Name	M.I.	Social Security Number

Street Address	Apt.	City	State	ZIP Code

Were you ever a member of EmblemHealth? ☐ NO ☐ YES If YES, member ID _____	**Marital Status:** ☐ Single ☐ Married ☐ Domestic Partner (DP)	**Birth Date:** Mo./Day/Yr.

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: 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, 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

Applicant's hours worked per week: ☐ At least 20 hours ☐ Less than 20 hours ☐ COBRA ☐ Retiree (see back of form**)	Home Tel. #: _____ Work Tel. #: _____
Type of Coverage: ☐ Individual ☐ Family ☐ Employee & Spouse/DP ☐ Employee & Child	
Email Address:	Cell Tel. # (see back of form*): _____
Note: If electing Young Adult Coverage, please submit a completed Young Adult Election Form.	☐ "Go Paperless" (see back of form)***
Primary Care Physician Name: (Not required for EPO/PPO members)	ID Number:
OB/GYN Selection Name: (Optional)	ID Number:

Are you covered by any other health insurance or Medicare? ☐ NO ☐ YES If YES, indicate.

Insurance Co. Name:

Insurance Co. Telephone #:	Type of Coverage:
Policy #:	Effective Date:

Check One:
- ☐ New Enrollment
- ☐ Reinstatement
- ☐ Termination
- ☐ Change

Status:
- ☐ Eligible Family Member
- ☐ Remove Dep.
- ☐ Address Change
- ☐ Name Change

Transfer:
- ☐ To Another Carrier
- ☐ 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/eligible children with different last name.

Spouse

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 Disabled[1]

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?

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☐ 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: _____

Eligible Family Member

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 Disabled[1]

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)
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Pronouns: What are your pronouns?

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Accessible format

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☐ Yes, Cuban ☐ Choose not to disclose

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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: _____

Eligible Family Member 2

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 Disabled**[1]

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

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☐ 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?

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☐ Portuguese ☐ Hindi ☐ American Sign Language ☐ Other Language ☐ Choose not to disclose

Current Health Insurance Information:
Carrier Name: _____ Coverage Begin Date: _____ Coverage End Date: _____

For eligible adult children incapable of self-sustaining employment, please see Section A on the back side of this form to check the appropriate "Add Eligible Family Membert" 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 :_____		
☐ 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 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

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? ☐ 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)

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 Eligible Family Member	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 Eligible Family Member	Eligible Family Member Adult Child Incapable of Self-Sustaining Employment	Disability Status Request Form
☐ Add Spouse ☐ Add Eligible Family Member	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 eligible family members applying for coverage
- Donate Life Registry for organ, eye, and tissue donation
- Eligible family members 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.