EmblemHealth

TRANSACTION FORM FOR GROUP ACCOUNTS

I. SUBSCRIBER INFORMATION

Last Name	First Name	M.I.	Sex	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

Birth Date: Mo. | Day | Yr.

Telephone #:
Home: _____
Work: _____

E-Mail Address: _____
☐ **"GO PAPERLESS" and save trees (see back of application)***

Young Adult Coverage: ☐ 26 And Under — Family ☐ 26 - 29 — Single Parent ID: _____

Subscriber Employment Status: _____
☐ Applicant working at least 20 hours per week

Disabled? ☐ NO ☐ YES

Primary Care Physician Name: (Not required for EPO/PPO members)
_____
ID Number: _____

OB/GYN Selection Name: (Optional)
_____
ID Number: _____

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

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 to Ind.

Status:
☐ Add Dependent
☐ 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

Last Name (if different)	First Name	Social Security Number	Sex	Relationship	Birth Date Mo.	Day	Yr.	✓ if Disabled	Primary Care Physician Name/ID Number (Not required for EPO/PPO members)	OB/GYN Selection Name/ID Number (Optional)
DEPENDENT				☐ Spouse ☐ DP ☐ Child				☐		
Current/Prior Health Insurance Information: Carrier Name: _____ Coverage Begin Date: _____ Coverage End Date: _____										
DEPENDENT				☐ Child				☐		
Current/Prior Health Insurance Information: Carrier Name: _____ Coverage Begin Date: _____ Coverage End Date: _____										
DEPENDENT				☐ Child				☐		
Current/Prior Health Insurance Information: Carrier Name: _____ Coverage Begin Date: _____ Coverage End Date: _____										

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

Your signature is required to process this form. Your signature attests that you have read the reverse side of this form.

Applicant must sign here: _____ **Date:** _____

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

Name of Group:	Group Number:	☐ EmblemHealth ☐ GHI ☐ GHI HMO ☐ HIP Plan Name: _____	**Type of Coverage:** ☐ Individual ☐ Family ☐ Employee & Spouse/DP ☐ Employee & Child
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 50 employees or fewer, you MUST complete Section A on the reverse side of this form. Required documentation MUST be attached to this Transaction Form to be processed.

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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 (50 employees or fewer), provide all necessary documentation.
2. All transactions are subject to EmblemHealth's retroactive policy (30 days for small groups, 90 days for large groups).
3. As part of New York State's "age 29" law, eligible young adults through age 29 (up to 30th birthday) may continue or 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.

Get more information at **www.emblemhealth.com**.

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

SECTION A

(To be completed by Benefits Administrator)

DOCUMENTATION BASED ON GROUP SIZE

ACTION Check (✔)One	Qualifying Event	Documentation Required	Group Type (Check One) → ☐ Sole Proprietorship or One-Subscriber Group	☐ Association of Two or More Employees	☐ Small Group — Less than 50 Employees
☐ Add Subscriber	New Hire or Change in Plan	For eligible employees who work more than 20 hours weekly, provide a recent Copy of NYS45 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 W4 form.	Not Eligible		
☐ Add Spouse	Marriage	**If last name is different** ☐ Marriage Certificate ☐ 1040 Form			
☐ Add Dependent	Birth Adoption	**If last name is different** ☐ Birth Certificate ☐ Formal Adoption Papers ☐ Court Approved Guardianship Papers			
☐ Add Spouse ☐ Add Dependent	Loss of Coverage	Certificate of Creditable Coverage			
☐ Add Domestic Partner	Domestic Partnership	Declaration of Cohabitation & Financial Interdependence form	Not Eligible	Not Eligible	

Note: No Retroactive Enrollments will be allowed. Members must be enrolled within 30 days from the Qualifying Event/next billing date.

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