EmblemHealth®

Young Adult Election and Eligibility Form

EmblemHealth & GHI Membership/P.O. Box 2820, New York, NY 10116-2820

FOR USE WHEN PURCHASING EXTENDED COVERAGE THROUGH AGE 29 FOR AN ELIGIBLE YOUNG ADULT

A young adult may be eligible to obtain extended coverage through a parent's group health insurance policy issued in New York State. He or she does not need to live with a parent, be financially dependent on a parent, or be a student. Dependents who previously lost their coverage because they reached the group plan's age limit are also eligible to re-enroll. The children of eligible young adults are NOT eligible for coverage.

By completing this form, the undersigned member or young adult is electing this continuation of coverage for the eligible young adult. The coverage will be the same as that which applies to the subscriber under the current group policy.

DIRECTIONS — Provide the following information in full, and submit the signed form **with the first premium payment** to the subscriber's employer.

SUBSCRIBER INFORMATION	
Subscriber Name	Subscriber SS#

YOUNG ADULT INFORMATION					
Last Name	First Name	MI	Date of Birth	Sex ☐ Male ☐ Female	Young Adult SS#
Young Adult Street Address		Apt	City	State	ZIP Code
Home Phone* ( )	Work Phone ( )	E-mail Address			☐ "Go Paperless" and Save Trees!†
Primary Care Physician Name (not required for EPO/PPO members)		Physician ID Number			

ELIGIBILITY REQUIREMENTS — Check the applicable boxes regarding the young adult's eligibility. **The Young Adult:**

- Is the unmarried child of the employee or member/subscriber insured under the policy ☐ Yes ☐ No
- Is under age 30 ☐ Yes ☐ No
- Lives, works or resides in New York State, or in the plan's service area ☐ Yes ☐ No
- Is not covered by or eligible for health benefits through his or her own employer ☐ Yes ☐ No
- Is not covered by or eligible for Medicare ☐ Yes ☐ No

ACKNOWLEDGMENT OF PREMIUM PAYMENT OBLIGATION

I understand and agree that I will be fully responsible for payment due with respect to the young adult coverage requested herein, which may not exceed 100% of the single premium rate.

*I understand that the phone number 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.

† 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.

I hereby certify that the subscriber is eligible for coverage under the group policy listed below as an employee of the group.

I hereby certify that the above statements regarding eligibility of the subscriber and the young adult named above are complete and correct to the best of my knowledge. *I agree to promptly advise EmblemHealth or GHI within 30 days of any change that affects the young adult's eligibility. I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claims containing any materially false information, or who conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.*

Applicant Signature_____ Print Name_____ Date_____

EMPLOYER INFORMATION		
Group Name	Group Number	
Group Administrator	Date Signed	Effective Date of Transaction