New York
Small Group Employee Enrollment Application
For Groups of 1–100[1] (Medical/Vision)
For Groups of 1–50 (Dental)

Empire BlueCross BlueShield
An Anthem Company

You, the employee, must complete this application. You are solely responsible for its accuracy and completeness.
To avoid the possibility of delay, answer all questions and be sure to sign and date your application.

Please complete in black ink only.

Section A: Employee Information

Last name	First name	M.I.	Social Security no.[2] (required)

Home address – Street and PO Box if applicable

City	County	State	ZIP code

Primary phone no.	Secondary phone no.	Marital status	Marriage date (MM/DD/YYYY)
		☐ Single ☐ Married ☐ Domestic Partner	

Employee email address

Employer name	Group no. (if known)

Employer street address

City	State	ZIP code

Employment status	Date of hire (MM/DD/YYYY)	Date of full-time employment (MM/DD/YYYY)	Date waiting period begins (MM/DD/YYYY)	No. of hours worked per week
☐ Full time ☐ Part time ☐ Retired				

Language choice (optional): ☐ English ☐ Spanish ☐ Chinese ☐ Korean ☐ Other – please specify: _____

Do you read and write English?
☐ Yes ☐ No If no, the translator must sign and submit a Statement of Accountability

Section B: Application Type

Select one

☐ New enrollment
☐ Open enrollment
☐ Rehire

☐ COBRA –
Select qualifying event
☐ Left employment
☐ Loss of dependent child status
☐ Medicare
☐ Reduction in hours
☐ Divorce or legal separation
☐ Covered employee's Medicare entitlement
☐ Death

Qualifying event date

☐ Mandatory Right of Election to continue Dependent coverage through age 29 (Qualified dependents only)

1 A small group must have at least one active full-time equivalent employee that meets the definition of employee in 42 U.S.C. 300gg-91(d)(5) but no more than 100 employees. A small group can consist of one non-spouse employee plus the business owner; a group of 100 would consist of the business owner plus 99 employees. Healthy New York coverage is only available for groups 1-50.
2 Empire is required by the Internal Revenue Service to collect this information.

Reset Form Save and Print

Social Security no.

Section C: Type of Coverage

1. Medical Coverage – select one plan option

All medical plans include pediatric dental coverage (up to age 19).

Member medical coverage – select one:
☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family ☐ No coverage

Please indicate the contract code for the medical plan selected. Contract code: _____

2. Dental Coverage – Please ask your employer which dental options are available before checking your selection.

Empire Family Dental and Empire Family Dental Enhanced plans include pediatric dental essential health benefits. All other plans including Empire Dental Prime and Complete with product families including Value, Classic, Enhanced, and Voluntary do not include pediatric dental essential health benefits. Your employer will advise you of your plan options. Please list below the contract code for the dental plan you select.

Member dental coverage – select one:
☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family ☐ No coverage
If waiving coverage for employee and/or any eligible family members, you must complete Section F.

Dental contract code – Please indicate the contract code for the dental plan chosen. Your employer will advise you of your plan options and contract codes.
Contract code: _____

3. Vision Coverage – select one plan option

Member vision coverage – select one:
☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family ☐ No coverage
If waiving coverage for employee and/or any eligible family members, you must complete Section F.

Vision contract code – Please indicate the contract code for the vision plan selected. Your employer will advise you of your plan options and contract codes.
Contract code: _____

Social Security no.

Section D: Coverage Information – All fields required. Attach a separate sheet if necessary.

Dependent information must be completed for any dependents to be covered. An eligible dependent may be your spouse/domestic partner (if this option is chosen by your employer), your children, or your spouse's children (or domestic partner's children if applicable). Dependent coverage will continue to the end of the calendar month in which the dependent turns age 26 unless:

- he or she qualifies as a disabled person, *If Dependent is over age disabled, please complete the Handicap/Dependent Form (HAC 506). You can find this form at http://www.empireblue.com/wps/portal/ehpemployer?content_path=employer/noapplication/f4/s3/t0/pw_ad067515.htm&rootLevel=3&label=Forms, or
- your employer has chosen extended dependent coverage for adult dependents through age 29 and your dependent qualifies, or
- you or the dependent have purchased a rider to extend coverage for young adults through age 29 and your dependent is eligible.

List all dependents below beginning with the eldest.

Employee Last name	First name	M.I.	Sex ☐ Male ☐ Female
Birthdate (MM/DD/YYYY)	Relationship to applicant **Self**		
Name of PCP you choose from our Pathway HMO/Small Group Provider Network[1]	PCP ID no.		Existing patient? ☐ Yes ☐ No

Spouse/Domestic Partner Last name	First name	M.I.	Sex ☐ Male ☐ Female
Birthdate (MM/DD/YYYY)	Social Security no.[2] (required)	Relationship to applicant ☐ Spouse ☐ Domestic Partner	
Name of PCP you choose from our Pathway HMO/Small Group Provider Network[1]	PCP ID no.		Existing patient? ☐ Yes ☐ No

Dependent Last name	First name	M.I.	Sex ☐ Male ☐ Female
Birthdate (MM/DD/YYYY)	Social Security no.[2] (required)	Relationship to applicant ☐ Child ☐ Make available age 29 adult dependent child (rider provided by your employer) ☐ Age 29 adult dependent child (rider purchased separately by you or the dependent) ☐ Other If other, what is relationship? ______	
Name of PCP you choose from our Pathway HMO/Small Group Provider Network[1]	PCP ID no.		Existing patient? ☐ Yes ☐ No
Does this dependent have a different address? ☐ **Yes** ☐ **No** **If yes, please enter:** ______			

Dependent Last name	First name	M.I.	Sex ☐ Male ☐ Female
Birthdate (MM/DD/YYYY)	Social Security no.[2] (required)	Relationship to applicant ☐ Child ☐ Make available age 29 adult dependent child (rider provided by your employer) ☐ Age 29 adult dependent child (rider purchased separately by you or the dependent) ☐ Other If other, what is relationship? ______	
Name of PCP you choose from our Pathway HMO/Small Group Provider Network[1]	PCP ID no.		Existing patient? ☐ Yes ☐ No
Does this dependent have a different address? ☐ **Yes** ☐ **No** **If yes, please enter:** ______			

Dependent Last name	First name	M.I.	Sex ☐ Male ☐ Female
Birthdate (MM/DD/YYYY)	Social Security no.[2] (required)	Relationship to applicant ☐ Child ☐ Make available age 29 adult dependent child (rider provided by your employer) ☐ Age 29 adult dependent child (rider purchased separately by you or the dependent) ☐ Other If other, what is relationship? ______	
Name of PCP you choose from our Pathway HMO/Small Group Provider Network[1]	PCP ID no.		Existing patient? ☐ Yes ☐ No
Does this dependent have a different address? ☐ **Yes** ☐ **No** **If yes, please enter:** ______			

1 To view our Pathway HMO/Small Group provider network, please log into Empireblue.com and look for "Find a Doctor" under "Useful Tools." To request a paper copy, please call your Broker or Empire representative.
2 Empire is required by the Internal Revenue Service to collect this information.

Social Security no.

Section E: Other Group Coverage

Are you or anyone applying for coverage currently eligible for Medicare?
☐ Yes ☐ No

If yes, give name: _____

Medicare ID no.	Medicare Part A effective date	Medicare Part B effective date	Medicare eligibility reason (check all that apply) ☐ Age ☐ Disability ☐ ESRD: Onset date:
Medicare Part D ID no.	Medicare Part D Carrier		Medicare Part D effective date

On the day your coverage begins, will you or a family member be covered by Medicare?
☐ Yes ☐ No

On the day your coverage begins, will you or a family member be covered by other health coverage?
☐ Yes ☐ No

On the day your coverage begins, will you or a family member be covered by other dental coverage?
☐ Yes ☐ No

If yes to any of these questions, please provide the following:

Name of person covered (Last name, first, M.I.)	Type (check one)	Coverage (check all that apply)	Carrier name	Carrier phone no.	Policy ID no.	Dates (if applicable)
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental				Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental				Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental				Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental				Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental				Start: End:

Section F: Waiver/Declining Coverage

Medical coverage declined for – check all that apply: ☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)

Dental coverage declined for – check all that apply: ☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)

Vision coverage declined for – check all that apply: ☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)

Sign here only if you are declining coverage.

Signature of applicant	Printed name	Date (MM/DD/YYYY)
X		

Social Security no.

Section G: Terms, Conditions and Authorizations

Please read this section carefully before signing the application.

Eligible employee:

- An employee of the Employer who works the number of hours per week to be eligible for benefits as defined by the Employer, who meets the definition of "employee" under New York State and Federal laws, and is approved by Empire as of the effective date. Employment must be verifiable from a current payroll listing or state or federal wage tax reports.
- An employee, as defined above, who enters into employment after the coverage effective date and who completes the group imposed waiting period for eligibility (if any) and applies for coverage within 45 days.
- Any other class of persons identified by the Employer, provided that written approval of their eligibility is obtained from the Company(ies); or
- Employees eligible for continued coverage under New York State or federal laws.

Eligible employee does not include consultants and independent contractors (1099 employees), temporary workers, directors and officers who do not qualify as owners, partners or employees, union members covered by a union-sponsored health plan, unless they meet the definition of "employee" under New York State and Federal laws.

Eligible dependent:

- Employee's spouse, or children age 26 or younger, which includes a newborn, natural child, or a child placed with the employee for adoption, a stepchild or any other child for whom the employee has legal guardianship or court ordered custody. The age limit for coverage of a child is (1) age 26 unless the employer has chosen extended dependent coverage and the dependent qualifies, (2) or you or the dependent have purchased a rider to extend coverage for young adults through age 29 and your dependent is eligible. In the case of (1) or (2), the dependent the age limit for coverage is age 30. Coverage for children will end on the last day of the month in which the children reach age 26, or age 30 if applicable.
- The contract age limit does not apply for initial or continued enrollment of an unmarried child who is incapable of self-sustaining employment because of mental illness, developmental disability, or mental retardation (as defined in the NYS mental hygiene law), or physical handicap. In order for the extended eligibility to apply, the child must have been in the incapacitated condition before s/he reached the age limit at which coverage would otherwise end under the benefit plan. The child must be chiefly dependent on the member for support and maintenance and must remain in the incapacitated condition to remain eligible. The member must submit proof of the child's incapacity within 31 days of the date the child reaches the termination age that would otherwise apply. (The employee will be asked to provide a physician's certification (HAC 506) of the dependent's condition.)
- Dependents eligible for continued coverage under New York State or federal laws.

For Health Savings Account enrollees: Except as otherwise provided in any agreement between me and the financial custodian, the custodian of my Health Savings Account (HSA), I understand that my authorization is required before the financial custodian may provide Empire with information regarding my HSA. I hereby authorize the financial custodian to provide Empire with information about my HSA, including account number, account balance and information regarding account activity. I also understand that I may provide Empire with a written request to revoke my authorization at any time.

In signing this application I represent that:

I certify each Social Security number listed on this application is correct.

By signing below, I (primary applicant) agree to receive my plan-related communications either by email or electronically. This may include my certificate, evidence of coverage, explanation of benefits statements, required notices or helpful information to get the most out of my plan. I agree to provide and update Empire with my current email address. I know that at any time I can change my mind and request a copy of these materials (or any specific materials) by mail, by contacting Empire.

As an eligible employee, I am requesting coverage for myself and all eligible dependents listed and authorize my employer to deduct any required contributions for this insurance from my earnings. I understand all benefits are subject to conditions stated in the Group Contract and coverage document.

I have read or have had read to me the completed application, and I realize any false statement or misrepresentation in the application may result in loss of coverage.

INSURANCE FRAUD STATEMENT: 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.

Sign here	Applicant signature X	Date (MM/DD/YYYY)

Social Security no.

Special Enrollment Rights

If you declined enrollment for yourself or your dependent(s) (including a spouse) because of other group health plan coverage, you can enroll yourself and your dependent(s) in this plan if you or your dependent(s) lose eligibility for the other group health plan due to any of the following: termination of employment; termination of the other group health plan; death of your spouse; legal separation, divorce or annulment; reduction of hours of employment; employer contributions toward the group health plan were terminated; or a child no longer qualifies for coverage as a child under the other group health plan. You must request enrollment within 31 days after coverage ends (or after the employer stops contributing toward the other coverage).

You may also enroll 31 days from the date you exhaust COBRA or state continuation coverage. In addition, if you have a dependent as a result of birth, adoption or placement for adoption, you may enroll yourself and your dependent(s) with newborn coverage starting on the date of birth provided that you request enrollment within 60 days after the birth, adoption or placement for adoption. Otherwise, coverage begins on the date we receive notice of the birth or adoption, provided you pay any additional premium when due. If you get married while covered, you can add your spouse effective on the date of your marriage if you tell us with 31 days. Otherwise, you must wait until your next open enrollment period. You, your spouse or child can also enroll within 60 days of the occurrence of the following circumstance: Either you or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility or you, your spouse or child become eligible for Medicaid or CHIP.

Sign here	Company officer signature **X**	Printed name	Title
Group no.		Tax ID no.	Date (MM/DD/YYYY)

Get help in your language

Language Assistance Services

Empire BlueCross BlueShield
An Anthem Company

Curious to know what all this says? We would be too. Here's the English version:
If you need assistance to understand this document in an alternate language, you may request it at no additional cost by calling the Member Services number (855-748-1806). (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the Member Services telephone number on the back of your ID card.

Spanish
Si necesita ayuda para entender este documento en otro idioma, puede solicitarla sin costo adicional llamando al número de Servicios para Miembros (855-748-1806). (TTY/TDD: 711)

Albanian
Nëse ju nevojitet ndihmë për ta kuptuar këtë dokument në një gjuhë tjetër, mund ta kërkoni pa kosto shtesë duke telefonuar në numrin e shërbimeve për anëtarët (855-748-1806). (TTY/TDD: 711)

Arabic
إذا احتجت إلى المساعدة لفهم هذا المستند بلغة أخرى، فيمكنك طلب المساعدة دون تكلفة إضافية من خلال الاتصال برقم خدمات الأعضاء (855-748-1806). (TDD/TTY: 711)

Bengali
একটি বিকল্প ভাষায় এই তথ্য পুস্তিকাটি বোঝার জন্য। যদি আপনার সহায়তার প্রয়োজন হয়, তাহলে কোনো অতিরিক্ত খরচ ছাড়া সদস্য পরিষেবা নম্বর (855-748-1806)-তে কল করে আপনি এটির অনুরোধ করতে পারেন। (TTY/TDD: 711)

Chinese
如果您需要協助以便以另一種語言理解本文件，您可以撥打成員服務號碼(855-748-1806)請求免費協助。(TTY/TDD: 711)

French
Si vous avez besoin d'aide pour comprendre ce document dans une autre langue, vous pouvez en faire la demande gratuitement en appelant les Services destinés aux membres au numéro suivant : 855-748-1806. (TTY/TDD: 711)

Greek
Αν χρειαστείτε βοήθεια για να κατανοήσετε το παρόν έγγραφο σε άλλη γλώσσα, μπορείτε να τη ζητήσετε χωρίς πρόσθετο κόστος καλώντας τον αριθμό του Τμήματος Υπηρεσιών Μέλους (855-748-1806). (TTY/TDD: 711)

Haitian
Si ou bezwen èd pou konprann dokiman sa a nan yon lòt lang, ou kapab rele nimewo Manm Sèvis la pou mande asistans gratis nan nimewo (855-748-1806). (TTY/TDD: 711)

Italian
Se ha bisogno di assistenza per la comprensione del presente documento in un'altra lingua, può richiederla senza alcun costo aggiuntivo chiamando il numero dedicato ai Servizi per i membri (855-748-1806). (TTY/TDD: 711)

Korean
다른 언어로 본 문서를 이해하기 위해 도움이 필요하실 경우, 추가 비용 없이 회원 서비스 번호(855-748-1806)로 전화를 걸어 도움을 요청할 수 있습니다. (TTY/TDD: 711)

Polish
Jeśli potrzebujesz pomocy w zrozumieniu niniejszego dokumentu w innym języku, możesz ją uzyskać bez ponoszenia dodatkowych kosztów, dzwoniąc do Działu Obsługi Klienta pod numer (855-748-1806). (TTY/TDD: 711)

Russian
Если вам нужна помощь, чтобы понять содержание настоящего документа на другом языке, вы можете бесплатно запросить ее, позвонив в отдел обслуживания участников (855-748-1806). (TTY/TDD: 711)

Tagalog
Kung kailangan ninyo ng tulong upang maunawaan ang dokumentong ito sa ibang wika, maaari ninyo itong hilingin nang walang karagdagang bayad sa pamamagitan ng pagtawag sa Member Services sa numerong (855-748-1806). (TTY/TDD: 711)

Urdu
تو آپ ممبر سروس نمبر پر کال اگر آپ کو کسی دوسری زبان میں اس دستاویز کو سمجھنے کے لیے مدد کی ضرورت ہو
جس کے لئے آپ پر کوئی اضافی اخراجات عائد نہیں ہوں گے نمبر کرکے اس کی درخواست کرسکتے ہیں
(711:TDD/TTY) (855-748-1806)

Yiddish
אויב איר דארפט הילף צו פארשטיין דעם דאקומענט אין אן אנדערע שפראך, קענט איר עס בעטן אהן קיין
עקסטערע קאסט דורך רופן די מעמבער באדינונגען נומער
(711:TDD/TTY) (855-748-1806)

It's important we treat you fairly
That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.