Employee Change Form
For 1–100[1] Employee Small Groups
New York

Empire BlueCross BlueShield
An Anthem Company

Consult the Evidence of Coverage for complete details regarding eligibility terms and criteria, and additional coverage terms.

Instructions:
Complete electronically or in black ink and return to your employer. Please use extra sheets of paper if necessary.

Section A: General Information

Employer name	Group no.	Employer tax ID no. (required)

Employee last name	Employee first name	M.I.	Employee Social Security no.[2] (required)

Section B: Employee Information – Required

Reason for change – Required. Check all that apply.

☐ Address change ☐ Add spouse/Domestic Partner or dependent ☐ Enrollment in Medicare (Fill in Section E)
☐ Name change ☐ Cancel spouse/Domestic Partner or dependent ☐ Cancel coverage
☐ Benefit change ☐ Change Primary Care Physician (PCP) ☐ Other: _____

☐ Add
☐ Change
☐ Cancel

Event reason – Required. Check all that apply.
☐ Open enrollment ☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Involuntary loss of coverage
☐ Other insurance ☐ Death ☐ Divorce ☐ Other[3] – please explain: _____

Event date/Requested effective date – Required ____/____/____ (MM/DD/YYYY)
Note: Requested effective date is subject to the terms of the Evidence of Coverage. See "When Coverage Begins" under "Who is Covered.""

Home address – Street and PO Box if applicable	City	State

ZIP code	County	Birthdate (MM/DD/YYYY)	Sex ☐ Male ☐ Female	Marital status ☐ Single ☐ Married ☐ Domestic Partner

Primary phone no.	Secondary phone no.	Email address

Name of PCP you choose from our Pathway HMO/Small Group Provider Network[4]	PCP ID no.	Existing patient? ☐ Yes ☐ No

Section C: Family Information – Spouse and dependents to be added/changed/cancelled. Attach a separate sheet if necessary.

☐ Add
☐ Change
☐ Cancel

Event reason – Required. Check all that apply.
☐ Open enrollment ☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Involuntary loss of coverage
☐ Other insurance ☐ Death ☐ Divorce ☐ Other[3] – please explain: _____

Event date/Requested effective date – Required ____/____/____ (MM/DD/YYYY)
Note: Requested effective date is subject to the terms of the Evidence of Coverage. See "When Coverage Begins" under "Who is Covered.""

Spouse/Domestic Partner last name	First name	M.I.	Social Security no.[2] (required)

Sex ☐ Male ☐ Female	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Spouse ☐ Domestic Partner

Name of PCP you choose from our Pathway HMO/Small Group Provider Network[4]	PCP ID no.	Existing patient? ☐ Yes ☐ No

Does the spouse/Domestic Partner have a different address? ☐ **Yes** ☐ **No**
If yes, please enter: _____

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.
2 Empire is required by the Internal Revenue Service to collect this information.
3 See Evidence of Coverage description of "Special Enrollment Periods" under "Who is Covered" for other event reasons.
4 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.

Reset Form Save and Print

Employee name	Social Security no.

Section C: Family Information — Continued

☐ Add ☐ Change ☐ Cancel	**Event reason — Required. Check all that apply.** ☐ Open enrollment ☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Involuntary loss of coverage ☐ Other insurance ☐ Death ☐ Divorce ☐ Other[1] – please explain: ____ **Event date/Requested effective date — Required** ____ (MM/DD/YYYY) **Note**: Requested effective date is subject to the terms of the Evidence of Coverage. See "When Coverage Begins" under "Who is Covered.""

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

Sex	Birthdate (MM/DD/YYYY)	Relationship to applicant
☐ Male ☐ Female		☐ Child ☐ Other If other, what is relationship? ____

Name of PCP you choose from our Pathway HMO/Small Group Provider Network[3]	PCP ID no.	Existing patient?
		☐ Yes ☐ No

Does this dependent have a different address? ☐ **Yes** ☐ **No**
If yes, please enter: ____

☐ Add ☐ Change ☐ Cancel	**Event reason — Required. Check all that apply.** ☐ Open enrollment ☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Involuntary loss of coverage ☐ Other insurance ☐ Death ☐ Divorce ☐ Other[1] – please explain: ____ **Event date/Requested effective date — Required** ____ (MM/DD/YYYY) **Note**: Requested effective date is subject to the terms of the Evidence of Coverage. See "When Coverage Begins" under "Who is Covered.""

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

Sex	Birthdate (MM/DD/YYYY)	Relationship to applicant
☐ Male ☐ Female		☐ Child ☐ Other If other, what is relationship? ____

Name of PCP you choose from our Pathway HMO/Small Group Provider Network[3]	PCP ID no.	Existing patient?
		☐ Yes ☐ No

Does this dependent have a different address? ☐ **Yes** ☐ **No**
If yes, please enter: ____

☐ Add ☐ Change ☐ Cancel	**Event reason — Required. Check all that apply.** ☐ Open enrollment ☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Involuntary loss of coverage ☐ Other insurance ☐ Death ☐ Divorce ☐ Other[1] – please explain: ____ **Event date/Requested effective date — Required** ____ (MM/DD/YYYY) **Note**: Requested effective date is subject to the terms of the Evidence of Coverage. See "When Coverage Begins" under "Who is Covered.""

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

Sex	Birthdate (MM/DD/YYYY)	Relationship to applicant
☐ Male ☐ Female		☐ Child ☐ Other If other, what is relationship? ____

Name of PCP you choose from our Pathway HMO/Small Group Provider Network[3]	PCP ID no.	Existing patient?
		☐ Yes ☐ No

Does this dependent have a different address? ☐ **Yes** ☐ **No**
If yes, please enter: ____

1 See Evidence of Coverage description of "Special Enrollment Periods" under "Who is Covered" for other event reasons.
2 Empire is required by the Internal Revenue Service to collect this information.
3 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.

Employee name	Social Security no.

Section D: Plan/Type of Coverage

1. Medical Coverage

Enter network name, product plan name and contract code selected. Please obtain from your employer:

Network name	Product plan name	Contract code, if known

Note for Health Savings Account (HSA) enrollees: If you enroll in an HSA plan, Empire BlueCross BlueShield will facilitate the opening of a Health Savings Plan in your name, if directed by your employer.

Member medical coverage – select one: ☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family

2. Dental Coverage

Product plan name	Contract code, if known

Member dental coverage – select one: ☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family

3. Vision Coverage

☐ I am enrolling in my Employer's vision plan, if any.	Contract code, if known

Member vision coverage – select one: ☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family

Section E: Other Group Coverage

Is anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ No If yes, give name: _____

Medicare ID no.	Part A effective date	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	Part D effective date

Is anyone applying for coverage covered by other health coverage? ☐ Yes ☐ No If yes, 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.	Policy holder name	Dates (if applicable)
	☐ Individual ☐ Group	☐ Health ☐ Dental					Start: End:
	☐ Individual ☐ Group	☐ Health ☐ Dental					Start: End:
	☐ Individual ☐ Group	☐ Health ☐ Dental					Start: End:
	☐ Individual ☐ Group	☐ Health ☐ Dental					Start: End:

Employee name	Social Security no.

Section F: 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 and who meets the definition of "employee" under New York State and Federal laws. and accepted by Empire as of the effective date. Employment must be verifiable from 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 age 26 unless the employer has chosen extended dependent coverage and the 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, in which case 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 the initial enrollment or maintaining enrollment of an unmarried child who cannot support himself or herself because of mental retardation, mental illness, or physical incapacity that began prior to the child reaching the age limit. Coverage may be obtained for the child who is beyond the age limit at the initial enrollment if the employee provides proof of handicap and dependence at the time of enrollment. (The employee may be asked to provide a physician's certification of the dependent's condition.) Consult Evidence of Coverage for complete eligibility terms for overage dependents incapable of self-sustaining employment due to handicap.
- 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.

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.

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.

I have read or have had read to me the completed application.

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)

Sign here	Company officer signature X	Printed name	Title	Date (MM/DD/YYYY)

Please fax completed application to 1-800-780-1224.

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.