HIP Subscriber/Member Enrollment Form

Last Name	First Name	M.I.	Sex	Social Security Number

Street Address	Apt.	City	State	Zip Code

Were you ever a member of HIP? ☐ NO ☐ YES
If yes, indicate policy number(s): ____________________

Marital Status: ☐ Single ☐ Married ☐ Divorced

Birth Date: Mo. | Day | Yr.

Telephone #: Home: (____) ______________ Work: (____) ______________
E-Mail Address: ________________________________

Primary Care Physician: (*not required for EPO/PPO members*)
Physician Name ____________________
Physician ID Number ____________________

OB/GYN Selection: (*Optional*)
Physician Name ____________________
Physician ID Number ____________________

Prior Health Insurance Information
Carrier Name ________________________________
Coverage Begin Date __/__/__ Coverage End Date __/__/__

Qualifying Event: ☐ Birth/Adoption ☐ Marriage ☐ Loss of Coverage ☐ New Hire ☐ ______________ **Qualifying Event Date:** Mo.____ Day______ Yr.

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: ___ / ___ / ___

Is your spouse 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: ___ / ___ / ___

**** If you are enrolling for your spouse and/or children, please list each one below – see Election of Coverage for eligibility***

Last Name (if different)	First Name	Soc. Sec. No.	Sex	Relationship	Birth Date Mo.	Day	Yr.	Check if disabled	Primary Care Physician Name/Number (*not required for EPO/PPO members*)	OB/GYN Selection Name/Number (*Optional*)
SPOUSE		_ _ _ - _ _ - _ _ _ _		☐ Wife ☐ Husband ☐ Other						
Prior Health Insurance Information		Carrier Name ______________		Coverage Begin Date__/__/__			Coverage End Date __/__/__			
ADDITIONAL DEPENDENTS (List oldest first)		_ _ _ - _ _ - _ _ _ _		☐ Son ☐ Daughter						
Prior Health Insurance Information		Carrier Name ______________		Coverage Begin Date__/__/__			Coverage End Date __/__/__			
		_ _ _ - _ _ - _ _ _ _		☐ Son ☐ Daughter						
Prior Health Insurance Information		Carrier Name ______________		Coverage Begin Date__/__/__			Coverage End Date __/__/__			
		_ _ _ - _ _ - _ _ _ _		☐ Son ☐ Daughter						
Prior Health Insurance Information		Carrier Name ______________		Coverage Begin Date__/__/__			Coverage End Date __/__/__			
		_ _ _ - _ _ - _ _ _ _		☐ Son ☐ Daughter						
Prior Health Insurance Information		Carrier Name ______________		Coverage Begin Date__/__/__			Coverage End Date __/__/__			

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**______________

THIS SECTION TO BE COMPLETED BY EMPLOYER/CONTRACTOR GROUP

Name of Group	Group Number

Select One: ☐ HIP PRIME HMO ☐ HIP PRIME POS ☐ HIP SELECT EPO ☐ HIP*access* I ☐ HIP*access* II ☐ HIP SELECT PPO ☐ HIP PRIME EPO ☐ HIP PRIME PPO ☐ HIP CLASSIC HMO

Requested Effective Date	Hire Date	Employee Title	Date Submitted to HIP	Approved by (*Representative of Benefits Administrator*)

Type of Coverage: ☐ Individual ☐ Employee & Spouse ☐ Family ☐ Employee & Child

Instructions to Benefit Administrators or Group Representatives: For Groups with 50 employees or less, you **MUST** complete Section A on the reverse side of this form. Required documentation MUST be attached to this Enrollment Form to be processed.

FOR HIP USE ONLY

PROCESSED BY	RECEIVED DATE	PROCESSED DATE

FORM 16-1613 10/02

HIP HEALTH PLAN OF NEW YORK, P.O. Box 2806, New York, NY 10116-2806

9798/m

ELECTION OF COVERAGE

I am enrolling for coverage for myself, my spouse and unmarried children under the age limit shown on the group schedule of benefits who are full time students at an accredited educational institution and who are dependent on me and/or my spouse for support.

If I am required to contribute to the premium for my coverage, I hereby authorize my employer to deduct such contributions in advance from wages due me and to remit same to HIP.

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 be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

HIP PRIME POS and HIP*access* II applicants please note that your benefits are provided under two separate contracts: a HIP, HMO contract issued by the Health Insurance Plan of Greater New York and HIP PRIME POS and HIP*access* II contract issued by the HIP Insurance Company of New York. Both contracts will end simultaneously if your HIP PRIME POS or HIP*access* II coverage ends.

The following paragraph pertains to small business groups only.

I understand that pre-existing conditions will not be covered during the first 12 months of my enrollment under my group's contract. A pre-existing condition is a condition (whether physical or mental) regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended by a duly licensed medical professional or received within the six (6) month period ending on the enrollment date. Except that, pregnancy is not considered a pre-existing condition and genetic information may not be treated as a pre-existing condition in the absence of a diagnosis of the condition related to such genetic information. HIP will credit the time I/we were covered by the previous policy, provided that the break in coverage under this plan does not exceed sixty-three (63) days, exclusive of any waiting periods. I agree that after enrolled, I will upon request provide HIP and/or my medical group with information on pre-existing conditions and any previous coverage I had. Subject to the applicable State and Federal laws pertaining to pre-existing conditions and creditable coverage, benefits for pre-existing conditions may not be payable for up to twelve months from my effective date under my group's contract.

SECTION A — DOCUMENTATION BASED ON GROUP SIZE

(To be completed by Benefits Administrator)

Group Type (Check One) →

ACTION **Check (✔)One**	Qualifying Event	Documentation Required	☐ 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** copy of Payroll documentation reflecting the date, employee's name and Social Security # **and** the employee's current year W4 form.	Not Eligible		
☐ Add Spouse	Marriage	Marriage Certificate			
☐ Add Dependent	Birth	☐ Birth Certificate or			
	Adoption	☐ Formal Adoption Papers or			
		☐ Court Approved Guardianship Papers			
☐ Add Spouse ☐ Add Dependent	Loss of Coverage				
		Certificate of Creditable Coverage			

Note: *No Retroactive Enrollments will be allowed. Members must be enrolled within 30 days from the Qualifying Event.*