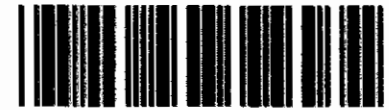




TRANSACTION FORM FOR GROUP ACCOUNTS



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? <input type="checkbox"/> NO <input type="checkbox"/> YES If YES, member ID _____		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner		Birth Date: Mo. Day Yr.		Telephone #: Home: (____) _____ Work: (____) _____		E-Mail Address: _____ <input type="checkbox"/> "GO PAPERLESS" and save trees (see back of application)*			
Young Adult Coverage: <input type="checkbox"/> 26 And Under — Family <input type="checkbox"/> 26 - 29 — Single Parent ID: _____						Subscriber Employment Status: _____ <input type="checkbox"/> Applicant working at least 20 hours per week					
Disabled? <input type="checkbox"/> NO <input type="checkbox"/> 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? <input type="checkbox"/> NO <input type="checkbox"/> YES If YES, indicate: Insurance Co. Name: _____ Insurance Co. Telephone #: (____) _____ Type of Coverage: _____ Policy #: _____ Effective Date: ____/____/____				Check One: <input type="checkbox"/> New Enrollment <input type="checkbox"/> Reinstatement <input type="checkbox"/> Termination <input type="checkbox"/> Change to Ind.		Status: <input type="checkbox"/> Add Dependent <input type="checkbox"/> Remove Dep. <input type="checkbox"/> Address Change <input type="checkbox"/> Name Change		Transfer: <input type="checkbox"/> To Another Carrier <input type="checkbox"/> 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			✓ if Disabled	Primary Care Physician Name/ID Number (Not required for EPO/PPO members)	OB/GYN Selection Name/ID Number (Optional)
					Mo.	Day	Yr.			
DEPENDENT				<input type="checkbox"/> Spouse <input type="checkbox"/> DP <input type="checkbox"/> Child						
Current/Prior Health Insurance Information:		Carrier Name: _____		Coverage Begin Date: ____/____/____		Coverage End Date: ____/____/____				
DEPENDENT				<input type="checkbox"/> Child						
Current/Prior Health Insurance Information:		Carrier Name: _____		Coverage Begin Date: ____/____/____		Coverage End Date: ____/____/____				
DEPENDENT				<input type="checkbox"/> 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:	<input type="checkbox"/> EmblemHealth <input type="checkbox"/> GHI <input type="checkbox"/> GHI HMO <input type="checkbox"/> HIP Plan Name: _____		Type of Coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Employee & Spouse/DP <input type="checkbox"/> 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.

* Do you need Ortho — yes — No (Only Dependents under 20 years of Age are eligible.)