EmblemHealth

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? ☐ NO ☐ YES
If YES, member ID _____

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner

Birth Date: Mo. | Day | Yr.

Telephone #:
Home: (____) _____
Work: (____) _____

E-Mail Address: _____
☐ **"GO PAPERLESS" and save trees (see back of application)***

Young Adult Coverage: ☐ 26 And Under — Family ☐ 26 - 29 — Single Parent ID: _____

Subscriber Employment Status: _____
☐ Applicant working at least 20 hours per week

Disabled? ☐ NO ☐ 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?
☐ NO ☐ YES If YES, indicate:
Insurance Co. Name: _____
Insurance Co. Telephone #: (____) _____ Type of Coverage: _____
Policy #: _____ Effective Date: ___/___/___

Check One:
☐ New Enrollment
☐ Reinstatement
☐ Termination
☐ Change to Ind.

Status:
☐ Add Dependent
☐ Remove Dep.
☐ Address Change
☐ Name Change

Transfer:
☐ To Another Carrier
☐ 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 Mo.	Day	Yr.	✓ if Disabled	Primary Care Physician Name/ID Number (Not required for EPO/PPO members)	OB/GYN Selection Name/ID Number (Optional)
DEPENDENT		- -		☐ Spouse ☐ DP ☐ Child						
Current/Prior Health Insurance Information:	Carrier Name: _____			Coverage Begin Date: ___/___/___	Coverage End Date: ___/___/___					
DEPENDENT		- -		☐ Child						
Current/Prior Health Insurance Information:	Carrier Name: _____			Coverage Begin Date: ___/___/___	Coverage End Date: ___/___/___					
DEPENDENT		- -		☐ 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:	☐ EmblemHealth ☐ GHI ☐ GHI HMO ☐ HIP Plan Name: _____	**Type of Coverage:** ☐ Individual ☐ Family ☐ Employee & Spouse/DP ☐ 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.

16-1613 12/11

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