



# TRANSACTION FORM FOR GROUP ACCOUNTS

MEMBERSHIP / P.O. BOX 2820 • NEW YORK, NY 10116-2820

(Please read important information on back before completing this form)

INTERNAL USE ONLY  
CONTROL NUMBER

## I. SUBSCRIBER INFORMATION

LAST NAME		FIRST NAME		M.I.	TELEPHONE NUMBERS <b>HOME</b>			<b>WORK</b>		<b>FAX</b>	
HOME ADDRESS (Include Apartment Number)					SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other _____				
CITY		STATE		ZIP CODE		EMPLOYMENT STATUS <input type="checkbox"/> Employed <input type="checkbox"/> Not-Employed <input type="checkbox"/> Retired <input type="checkbox"/> COBRA <input type="checkbox"/> RETIREE/RDS - EFFECTIVE DATE _____				PRIMARY LANGUAGE SPOKEN	

## II. ENROLLMENT INFORMATION

NAME			DATE OF BIRTH	SOCIAL SECURITY	SEX	RELATION-	MAILING ADDRESS	EMAIL ADDRESS	FULL TIME	ADD	DELETE	RACE/ETHNICITY
LAST	FIRST	M.I.	MO/DAY/YR	NUMBER		SHIP	(If different from above)		STUDENT (✓)	(✓)	(✓)	(CODES BELOW)
SUBSCRIBER						SELF						
SPOUSE												
DEPENDENT												
DEPENDENT												
DEPENDENT												

## III. OTHER CARRIER INFORMATION Do you or any of your dependents have other health care coverage? Yes Please complete this section No GO TO SECTION IV

NAME OF OTHER INSURANCE CARRIER		TYPE OF CONTRACT <input type="checkbox"/> Group <input type="checkbox"/> Individual		NAME OF POLICY HOLDER		LAST NAME		FIRST NAME		M.I.
CARRIER'S ADDRESS			CITY		STATE	ZIP CODE	POLICY NUMBER		EFFECTIVE DATE	

## IV. DID YOU HAVE PRIOR HEALTH COVERAGE YES Please provide a 12-month history of all coverage in this section NO GO TO SECTION V

	NAME AND ADDRESS OF INSURER	TELEPHONE NUMBER OF INSURER	NAME OF POLICYHOLDER	POLICY I.D. NUMBER	EFFECTIVE DATE OF CURRENT OR PRIOR POLICY	TERMINATION DATE OF CURRENT OR PRIOR POLICY
HOSPITAL						
MEDICAL						

## V. EMPLOYER INFORMATION

GHI CERTIFICATE NUMBER OR EMPLOYEE SOCIAL SECURITY NUMBER	DATE OF HIRE	EMPLOYEE WAITING PERIOD <input type="checkbox"/> YES NUMBER OF WAITING PERIOD DAYS _____ <input type="checkbox"/> NOT APPLICABLE	NUMBER OF ACTIVE EMPLOYEES IN YOUR GROUP _____
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**Check one:**  New Enrollment  Reinstatement  Termination

**STATUS CHANGE:**  Add Dependent  Remove Dependent  Address Change  Name Change Reason for Change: \_\_\_\_\_

**TRANSFER:**  To Another Carrier  GHI Group # Change: From \_\_\_\_\_ To \_\_\_\_\_ Is applicant currently working at least 20 hours per week?  Yes  No

## VI. SUBSCRIBER AUTHORIZATION

### GROUP AUTHORIZATION

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim concerning 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, shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Subscriber Signature _____	Date _____	Authorized Signature _____	Date _____	Phone Number _____
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## VII. GROUP NAME AND ADDRESS

### EFFECTIVE DATE OF TRANSACTION

### GHI GROUP NUMBER

	MEDICAL	MEDICAL
	HOSPITAL	HOSPITAL
	DENTAL	DENTAL

RACE/ETHNICITY CODES: (Optional) A = ASIAN B = BLACK OR AFRICAN AMERICAN C = CAUCASIAN H = HISPANIC OR LATINO  
 I = NATIVE AMERICAN OR ALASKAN NATIVE P = NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER O = OTHER **SEE INFORMATION/EXPLANATION ON REVERSE SIDE**

## IMPORTANT INFORMATION

- 1- The subscriber must complete sections I through IV. The group plan administrator must complete section V. Both the subscriber and the administrator must complete section VI.
- 2- All effective dates of transactions may not exceed thirty (30) days retroactive from the next billing date.
- 3- For group accounts with student dependent coverage: A full-time dependent student is a person who meets all of the following conditions:  
He/she is at least 19 years of age, unmarried, receives at least half of his/her support from the employee or member, and is enrolled full-time in an accredited educational institution. The institution must grant a degree or diploma. The student must be listed as a dependent when you enroll for coverage.  
To enroll the dependent as a full-time student, attach a complete Student Dependent Certification Form or attach a copy of the most recent Bursar's receipt. See your group plan administrator for a Dependent Student Certification Form.
- 4- Failure to complete any part of this form (e.g., group number, reason for submission, certificate number, etc.) will delay the processing of the transaction.
- 5- Failure to have the proper signatures and authorization will require GHI to return this transaction form to the employer group administrator.

### Why We Ask You for Race/Ethnicity Information

National studies show that differences in access to health care occur along ethnic lines. In our effort to ensure that everyone we serve receives appropriate care, GHI, along with other health insurers, is collecting data on ethnicity with the goal of improving access to care and outcomes for groups who often have poorer results. Information will only be used by our Medical Department to improve access to needed care and will not be available to any other staff. Answering this question is voluntary.

### GHI Web Site

For fast, convenient access to the latest claim status, eligibility, and benefits information, visit GHI's secure Web site at [www.ghi.com](http://www.ghi.com). Available around the clock, on the site you can also find provider listings, order ID cards, view an online Explanation of Benefits, access wellness information, and much more.

### Translation Services

If English is not your primary language and translation services are needed when calling GHI Customer Service, a representative can help you.