HEALTH INSURANCE ENROLLMENT FORM

an EmblemHealth company

THE GHI/CUNY STUDENT HEALTH INSURANCE PROGRAM FOR MATRICULATED STUDENTS WITH SIX OR MORE CREDITS PER SEMESTER AND THEIR DEPENDENTS

P.O. BOX 2820, NEW YORK, NY 10116-2820

SUBSCRIBER INFORMATION

LAST NAME	FIRST NAME	MI	SOC. SEC. NO. OR STUDENT ID NO.	COLLEGE

HOME ADDRESS	DATE OF BIRTH	SEX	RACE/ETHNICITY (SEE CODES)
		☐ MALE ☐ FEMALE	

CITY	STATE	ZIP	TELEPHONE NUMBERS: HOME	CELL	EMAIL ADDRESS

SPOUSE/DOMESTIC PARTNER INFORMATION - To be completed if this person is to be covered by the subscriber.

(Check One:) This is coverage for my ☐ spouse ☐ domestic partner Does this person have own coverage? ☐ No ☐ Yes

LAST NAME	FIRST NAME	MI	SOC. SEC. NO. OR STUDENT ID NO.	DATE OF BIRTH

Please provide the following information for your current or prior plan.

	Name and Address of Insurer	Telephone Number of Insurer	Name of Policyholder	Policy ID Number	Effective Date of Policy	Termination Date of Policy
Hospital						
Medical						

Is there a waiting period for pre-existing conditions under your existing plan? ☐ No ☐ Yes If yes, please indicate the effective date of your existing plan. ___________________________________

PRE-EXISTING CONDITION LIMITATION: THERE WILL BE AN ELEVEN-MONTH WAITING PERIOD UNDER THE GHI CUNY PROGRAM FOR BENEFITS FOR ANY CONDITION FOR WHICH MEDICAL ADVICE OR TREATMENT WAS RECOMMENDED OR RECEIVED DURING THE SIX-MONTH PERIOD ENDING ON THE ENROLLMENT DATE. THIS WAITING PERIOD WILL BE REDUCED TO THE EXTENT THAT YOU ARE ENTITLED BY LAW TO A CREDIT FOR PRIOR CONTINUOUS CREDITABLE COVERAGE.

DEPENDENT INFORMATION - List Dependent Children

NAME (INDICATE DIFFERENT LAST NAME IF APPLICABLE) LAST	FIRST	MI	DATE OF BIRTH MO/DAY/YR	SOCIAL SECURITY NUMBER	SEX	RELATION-SHIP	MAILING ADDRESS (If different from above)	EMAIL ADDRESS	RACE/ETHNICITY (SEE CODES)
				- -					
				- -					
				- -					
				- -					

MONTHLY RATES FOR THE GHI/CUNY STUDENT HEALTH INSURANCE PROGRAM:

Individual:	☐	**$229.68**
Family:	☐	**$654.61**

SECTION TWO: To Be Completed by Authorized Person in the Registrar's Office of the Student's Educational Institution (Affix the Institution's Seal or Stamp Where Indicated Below).

Semester: ☐ Fall ☐ Spring |___|___| |___|___| Year of Study (Circle One): 1st 2nd 3rd 4th 5+

Month Year

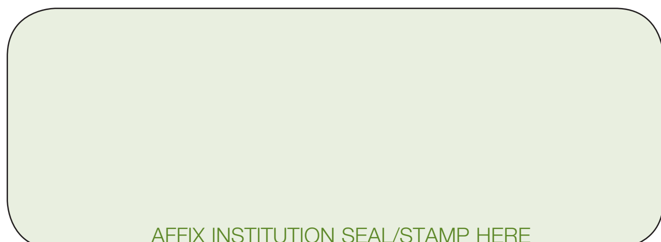
In order for GHI to determine a student's eligibility for the GHI/CUNY program, please complete the following information:

1. Is the student enrolled for six credits or more this semester? ☐ Yes ☐ No
2. Student's program of study? ___________________________________
3. Student's expected degree or diploma? ___________________________________
4. Registrar's telephone number: ___________________________________

____

Authorized Signature/Title

Mail Validated Form to: GHI
P.O. Box 2820
New York, NY 10116-2820



DESIRED EFFECTIVE DATE OF COVERAGE

If your completed application is received between the first and the fifteenth of the month, your effective date of coverage will be the first of the month in which this form is received. If your enrollment form is received after the fifteenth of the month, your effective date will be the first of the following month. Deadline to enroll is **November 30, 2009.**

BEFORE DATING AND SIGNING THIS FORM, PLEASE MAKE SURE YOU HAVE ANSWERED ALL QUESTIONS. ALSO, BE SURE YOU HAVE CHECKED THE APPROPRIATE BOXES FOR THE TYPE OF COVERAGE YOU DESIRE.

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, 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.

___________________________________ SUBSCRIBER'S SIGNATURE

_______________ DATE

Group Health Incorporated (GHI) is an EmblemHealth company.