Application for Individual Off-Exchange Direct Pay HMO

EmblemHealth®

Instructions

- Please type or print firmly with ballpoint pen.
- This application may be used to apply for new enrollment, or to change your type of contract. Complete this application if you or your spouse, or both, are not eligible for Medicare due to age. Your contract should be appropriate (Individual, Family, Child Only) to your status as indicated below:

  Individual
  - If you are unmarried, widowed, divorced, or legally separated and have no dependent children.
  - If you are married without dependent children, and each spouse would prefer their own individual contract.
  - If your spouse is Medicare eligible, and/or you have dependents under the age of 26 and do not wish to purchase a policy that covers dependents.

  Family
  - If you are married, or if you are married with dependent children. If you are married and your spouse is eligible for Medicare, and you're covering one or more dependents under age 26, you should apply for a Family contract for you and your child(ren). Your Medicare-eligible spouse should apply for separate coverage using a Non-Group Medicare Supplement Insurance Application Form.
  - If you are unmarried, widowed, divorced, or legally separated and you're covering one or more dependent children.
  - If you have one or more dependent children under 26 years of age, complete only one application for Family coverage for yourself and your children.

  Child Only
  - If you are purchasing coverage for a child only. This contract will not provide coverage for the Responsible Adult.
  - If you are the Responsible Adult for a child under 21 years of age. Children covered under this contract include natural children, legally adopted children, step children, children for whom the Responsible Adult is the proposed adoptive parent, and children for whom the Responsible Adult is the legal guardian. Foster children and grandchildren of the Responsible Adult are not covered.
  - If you would like to purchase a Child Only contract for more than one child, please complete a separate application for each additional child.
- When submitting your completed application, you must include a check or money order.
- All applicants must:

  1. Complete, sign, and date the application where indicated.
  2. Check the appropriate boxes for type of coverage and type of contract.
  3. Return the completed application with a check or money order (a postage paid envelope is enclosed) to:
     EmblemHealth
     ATTN: IND DM
     Sales Direct Pay
     55 Water Street, 8th Floor
     New York, NY 10041-8190

Payable Amount $	Check No.	Money Order No.

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

PRINT IN INK

Type of Contract: ☐ Individual Contract ☐ Individual & Spouse ☐ Parent & Child(ren)
☐ Family Contract (Individual/Spouse & Child(ren) ☐ Child Only

Plan Selection: For plan selection see attached rate sheet for applicable rates. Requested Plan start date: _____

Please specify Plan: ☐ Bronze ☐ Silver ☐ Gold ☐ Platinum ☐ Catastrophic ☐ Gold Value D ☐ Silver Value D

- All enrollees/members requesting enrollment after the end of Open Enrollment must have a qualifying life event in order to be eligible for health insurance coverage. For more information, check the enclosed document about qualifying life events.
- Please check here if you are you applying after the end of Open Enrollment with a qualifying life event. ☐

1. Please complete the following information for the subscriber.			
Full Name	Date of Birth (M/D/Y)	Social Security Number	Sex: ☐ Male ☐ Female
Home Address (P.O. Box is not acceptable)	Telephone Numbers Cell: Home: Work:		
City	County	State	Zip Code
Mailing Address (If different from Home Address)			
City	County	State	Zip Code
Applicant Email Address	☐ "Go Paperless" (see below)		

2. Please complete the following spouse and/or dependent child(ren) information if applying for a Family Contract.
A dependent child will be covered until the end of the month in which he/she becomes 26 years of age.

Last Name	First Name	M.I.	Date of Birth (M/D/Y)	Relationship	Telephone (Daytime)
Mailing Address (If different from above)		Sex (M/F)	Social Security Number	Email Address	
Last Name	First Name	M.I.	Date of Birth (M/D/Y)	Relationship	Telephone (Daytime)
Mailing Address (If different from above)		Sex (M/F)	Social Security Number	Email Address	
Last Name	First Name	M.I.	Date of Birth (M/D/Y)	Relationship	Telephone (Daytime)
Mailing Address (If different from above)		Sex (M/F)	Social Security Number	Email Address	
Last Name	First Name	M.I.	Date of Birth (M/D/Y)	Relationship	Telephone (Daytime)
Mailing Address (If different from above)		Sex (M/F)	Social Security Number	Email Address	

By electing "Go paperless," you will receive claim statements and some other EmblemHealth letters by email instead of paper mail. You will be able to view your Explanation of Benefits (EOBs) under the Claims portal of the EmblemHealth Website. Your enrollment in the "Go Paperless" option will continue as long as your account remains active, or until you choose to discontinue this option.

By completing this form, I consent to receive calls from a representative about EmblemHealth products and services at the number I have provided (including mobile devices). These calls may be made using an automated technology and my consent to receive these calls is not required as a condition for me to make a purchase.

3. The Responsible Adult must complete the following child only information if applying for a **Child Only Contract**. A child will be covered until the end of the year in which he/she becomes 21 years of age.					
Dependent Last Name	First Name	M.I.	Date of Birth (M/D/Y)	Relationship	Telephone (Daytime)
Mailing Address (If different from above)		Sex (M/F)	Social Security Number	Email Address	
Dependent Last Name	First Name	M.I.	Date of Birth (M/D/Y)	Relationship	Telephone (Daytime)
Mailing Address (If different from above)		Sex (M/F)	Social Security Number	Email Address	
Dependent Last Name	First Name	M.I.	Date of Birth (M/D/Y)	Relationship	Telephone (Daytime)
Mailing Address (If different from above)		Sex (M/F)	Social Security Number	Email Address	
Dependent Last Name	First Name	M.I.	Date of Birth (M/D/Y)	Relationship	Telephone (Daytime)
Mailing Address (If different from above)		Sex (M/F)	Social Security Number	Email Address	

4. Please provide the following information for your current or prior health benefits plan (if any).

Type of Plan	Name and Address of Insurer	Telephone Number of Insurer	Name of Policyholder	Policy I.D. Number	Effective Date of Prior Policy	Termination Date of Prior Policy
Hospital		( )				
Medical		( )				

5.

Primary Care Physician (PCP)	PCP ID Number

6. If you are applying for individual coverage, and if your spouse is eligible for Medicare, check here. ☐

The Age 29 Rider will extend dependent child coverage to the end of the month he/she becomes 30 years of age and is available for purchase. Please refer to the included rate sheet. Please check the box and complete the information below if the dependent child(ren) require the purchase of the Age 29 Rider. ☐ **Purchase Age 29 Rider**

7. PLEASE SUBMIT PAYMENT WITH THIS APPLICATION IN THE ATTACHED POSTAGE PAID ENVELOPE.

If you are presently enrolled under a EmblemHealth Direct Payment Hospital/Medical Plan and want to change your enrollment status, please check the appropriate box below.

☐ I wish to change my present coverage from Individual to Family.	☐ I wish to change my present coverage from Family to Individual.

I hereby apply for the (specify Plan Selection) ____

If this application is for a family contract, I have provided the names of my spouse and dependent child(ren) under 26 years of age.
If this application is for child only coverage, as the responsible adult I have provided the child(ren) under 21 years of age. If I have selected to purchase the Age 29 Rider I have included those dependent children under 29 years of age. I make this application on their behalf as well as my own.

When the application is processed, coverage will be effective only if payment is received in accordance with the invoice. I represent and understand that:

A. On my enrollment date, my existing contract(s), if any, will be canceled.
B. All statements and answers in this application are true to the best of my knowledge and belief.

NOTE: BEFORE DATING AND SIGNING THIS APPLICATION, PLEASE MAKE SURE YOU HAVE ANSWERED ALL THE QUESTIONS, AND HAVE CHECKED THE APPROPRIATE BOX FOR 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 purposes 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.

Applicant's Signature (Do Not Print)		Date Signed
Applicant's Spouse's Signature (Do Not Print)	Necessary Only When Applying For Family Coverage	Date Signed
Responsible Adult's Signature (Do Not Print)	Necessary Only When Applying For Child Only Coverage	Date Signed

EmblemHealth Website

For fast, convenient access to the latest claim status, eligibility, and benefits information, visit EmblemHealth's secure member website at **emblemhealth.com**. Available around the clock, the site offers provider listings, enables you to order ID cards, view an online Explanation of Benefits, access wellness information, and much more.

EmblemHealth Customer Service

Language assistance services, free of charge, are available to you. Call **877-411-3625** (TTY: **711**).

For EmblemHealth Office Use Only

	(Initials)	(Initials)
Date Application Issued	_____	_____
Date Application Received	_____	_____
Date Application Processed	_____	_____
Date, Contract and Copy of Application Sent	_____	_____
Type of Plan	_____	_____
Group Number	_____	_____
Benefit Set ID	_____	_____
Effective Date	_____	_____
Rep ID	_____	_____

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ATTENTION: Language assistance services, free of charge, are available to you. Call **1-877-411-3625** (TTY/TDD: **711**).

Español (Spanish)
ATENCIÓN: Usted tiene a su disposición, gratis, servicios de ayuda para idiomas. Llame al **1-877-411-3625** (TTY/TDD: **711**).

中文 (Traditional Chinese)
注意：我們免費提供相關的語言協助服務。請致電 **1-877-411-3625** (TTY/TDD: **711**)。

Русский (Russian)
ВНИМАНИЕ! Вам доступны бесплатные услуги переводчика. Звоните по тел. **1-877-411-3625** (служба текстового телефона TTY/TDD: **711**).

Kreyòl Ayisyen (Haitian Creole)
ATANSYON: Gen sèvis èd nan lang gratis ki disponib pou ou. Rele nimewo **1-877-411-3625** (TTY/TDD: **711**).

한국어 (Korean)
주의: 귀하에게 언어 지원 서비스가 무료로 제공됩니다. **1-877-411-3625**(TTY/TDD: **711**)번으로 전화하십시오.

Italiano (Italian)
ATTENZIONE: sono disponibili servizi gratuiti di assistenza linguistica. Chiami il numero **1-877-411-3625** (TTY/TDD: **711**).

אידיש (Yiddish)
אכטונג: שפראך הילף סערוויסעס, אהן קיין פרייז, זיינען דא צו באקומען פאר אייך. רופט **1-877-411-3625** (TTY/TDD: **711**).

বাংলা (Bengali)
মনোযোগ দিন: ভাষা সহায়তা পরিষেবাগুলি আপনার জন্য বিনামূল্যে উপলব্ধ আছে। **1-877-411-3625** (TTY/TDD: **711**) নম্বরে ফোন করুন।

Polski (Polish)
UWAGA: dostępna jest bezpłatna pomoc językowa. Prosimy zadzwonić pod numer **1-877-411-3625** (TTY/TDD: **711**).

العربية (Arabic)
يُرجى الانتباه: تتوفر لك خدمات المساعدة اللغوية مجاناً، اتصل على الرقم **1-877-411-3625** أو (TTY/TDD: **711**).

Français (French)
ATTENTION : une assistance d'interprétation gratuite est à votre disposition. Veuillez composer le **1-877-411-3625** (TTY/TDD : **711**).

اردو (Urdu)
وجہ دیں: آپ کے لیے زبان سے متعلق اعانت کی خدمات، مفت دستیاب ہیں۔ **1-877- 411-3625** (TTY/TDD: **711**) پر کال کریں۔

Tagalog (Tagalog)
NANANAWAGAN NG PANSIN: Mayroon kang magagamit na mga serbisyo para sa tulong sa wika nang walang bayad. Tawagan ang **1-877-411-3625** (TTY/TDD: **711**).

Ελληνικά (Greek)
ΠΡΟΣΟΧΗ: Διατίθενται για σας υπηρεσίες γλωσσικής βοήθειας, δωρεάν. Καλέστε το **1-877-411-3625** (για άτομα με προβλήματα ακοής (TTY/TDD): **711**).

Shqip (Albanian)
VINI RE: Shërbime ndihmore për gjuhën, falas, janë në dispozicionin tuaj. Telefononi në **1-877-411-3625** (TTY/TDD: **711**).

NOTICE OF NONDISCRIMINATION POLICY

EmblemHealth complies with Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. EmblemHealth does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

EmblemHealth:

- Provides free aids and services to people with disabilities to help
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose first language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call member services at **1-877-411-3625** (TTY/TDD: **711**).

If you believe that EmblemHealth has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with EmblemHealth Grievance and Appeals Department, PO Box 2844, New York, NY 10116, or call member services at **1-877-411-3625**. (Dial **711** for TTY/TDD services.) You can file a grievance in person, by mail or by phone. If you need help filing a grievance, EmblemHealth's Grievance and Appeals Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office of Civil Rights electronically through the Office of Civil Rights Complaint Portal, available at **ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail or phone at **U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201**; **1-800-368-1019**, (dial **1-800-537-7697** for TTY services).

Complaint forms are available at **hhs.gov/ocr/office/file/index.html**.