Independent Health.

Enrollment Application/Change Form

Please clearly **PRINT** all information

P.O. Box 710, Buffalo, NY 14231-0710 independenthealth.com

Employer Admin. Initials:	Date:

KEY

- † Supporting documentation required
- ‡ If allowed by plan; supporting documentation may be required
- \S Must include date of qualifying event

To avoid a delay in your health i	nsurance coverage, ple	ease be sure ALL SECTIONS	ARE COMPLETED
What type of insurance are you applying for (se	elect one)?		
Employer Group – actively employed 🔲 CC)BRA 🔲 Individual (ar	pplication must include paymer	nt and supporting documentation)
A Coverage Information			
Name of Employer (not needed for individuals no	ot associated with employe	r group)	
Account Number Sub A	ccount (if applicable)	Plan Name	
Effective Date (date the coverage for this applicant	**	Employee ID/Division/Ur	nion/Class (if applicable)
Failure to include a date in this field may result in a o	telay in your coverage.		
B Qualifying Event Information			
Enroll/Add Coverage (enter date and select	reason below) Date of	Qualifying Event:/_	/(ex: date of hire)
Check One:			
Open Enrollment	New Hire §	☐ Newborn §	Marriage §
Relocated/transfer §	Adoption/Guardiansh	ip† Involuntary Loss	of Coverage §
Change in Employment Status §	Domestic Partner ‡	Enrolling COBRA	A coverage
Other †			
☐ Disenroll/Cancel Coverage (enter date an	d select reason below) E	ffective date of cancellation	: / /
Check One:	,		
Terminate Employment Decea	sed D	ependent Max age reached	Divorced †
☐ Moved out of area ☐ No Ior	nger eligible N	onpayment	Other coverage
Layoff/Strike Cance	l coverage for entire fan	nily Cancel coverag	ge for all dependents only
Cancel coverage for the following dep	endents only:		
•••••	• • • • • • • • • • • • • • • • • • • •	• • • • • • • • • • • • • • • • • • • •	•••••
Change(s) to existing plan (enter date and	select reason below) Ef	fective date of change:	_//
Check One:			
Address Phone No.	Marital status	Last Name	☐ New Employment type*
*If new employment type check one box	c below:		
Active COBRA	Inactive	Surviving Insured	☐ TEFRA/DEFRA
Retired Check here if employee is changing to ret	ired status.		

Social Security Number (SSN) must be provided for the employee/individual and for ALL dependents. Any applications submitted without a SSN for each employee/individual may be delayed or denied. Please see your employer's Benefit Administrator if you are unable to supply a SSN for each applicant.

C Employee/marvidual	mormation				
	-				
Employee/Individual SSN					
Employee/Individual Last	Name First Name	Middle Initial			
Employee Status if Applica	ble A (Active) R (Retired)	C (Cobra)			
Address (PO Box not accepted		Apartment/Suite/Building			
Tidal ess (1 o Box not accepted	9	, spartment, saled, ballanig			
City	State Zip	Date of Birth (MM/DD/YYYY)			
	/	/			
	()				
Gender	Mobile Phone No. (include area cod	e) Home Phone No. (include area code)			
Email address		Primary Language (if other than English)			
Primary Care Physician (ref	er to Find A Doctor tool at independenthealt	h.com/findadoctor)			
Provider Name	Provider Address	Are you a current patient of this physician? (Y or N)			
	licate if you or anyone else on this application es only, and the answers you provide will have	will have other health insurance while enrolled with Independent Health.			
This is for informational parpose	.s omy, and the answers you provide will have	s no bearing on engionity.			
Insurance Carrier Name	Policy No./MBI	Name of Insured			
Are you or anyone included (on this application covered by Medicare	? Yes No Effective Date:			
Have you obtained stand-a	alone dental coverage that provides a	pediatric dental essential health benefit through			
a New York Health Benefit Exchange-certified stand-alone dental plan offered outside the New York Health					
Benefit Exchange? Yes	No No				
If you answered "yes," please provide the name of the company issuing the stand-alone dental coverage:					
If you answored " "	will halp cocure this coveres thus	a plan underswritten and administered b			
If you answered "no," we will help secure this coverage through a plan underwritten and administered by Delta Dental of New York, Inc. Additional premium may apply.					
_ J.t.a _ J.t.a. J. I IVEW TOTK,	Auditional promium may apply.				

Employee/Individual Socia	il Security Number				
Dependent #1					
	<u> </u>	† Supporting do	cumentation required ‡ If allowe	ed by plan; supporting documentation required	
Dependent SSN					
Relationship to Employee,	/Individual				
Spouse Child Grandchild ‡ Legal ward † Domestic Partner ‡ Other † (please specify)					
Dependent/Spouse Last N	lame	First Name	Middle Initial	Date of Birth (MM/DD/YYYY)	
<u> </u>	()	1 / 1 1	()		
Gender	Mobile Phone N	No. (include area code)	Home Pho	one No. (include area code)	
Email address			Primary La	anguage: (if other than English)	
Primary Care Physician (ref	fer to Find A Doctor too	ol at independenthealth.co	,	inguage. (ii other than English)	
Provider Name	Provider Ad	dress	Are you a current p	atient of this physician? (Y or N)	
Dependent #2					
	<u> </u>	† Supporting do	cumentation required ‡ If allowe	ed by plan; supporting documentation required	
Dependent SSN					
Relationship to Employee,	/Individual				
Spouse Child	Grandchild ‡	Legal ward †	Domestic Partner ‡	Other †(please specify)	
Dependent /Spouse Last N	lame	First Name	Middle Initial	Date of Birth (MM /DD /YYYY)	
Dependent/Spouse Last N	lame	First Name	Middle Initial	Date of Birth (MM/DD/YYYY)	
Dependent/Spouse Last N Gender	()	First Name	()	Date of Birth (MM/DD/YYYY) one No. (include area code)	
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	() Mobile Phone N	No. (include area code)	() Home Pho Primary La	. , , ,	
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Gender Email address Primary Care Physician (re) Provider Name Dependent #3 Dependent SSN Relationship to Employee, Spouse Child Dependent/Spouse Last N	Mobile Phone N Fer to Find A Doctor too Provider Add - - /Individual Grandchild ‡ Name () Mobile Phone N	No. (include area code) of at independenthealth.cod dress Supporting do Legal ward † First Name No. (include area code)	Primary Land Are you a current purcumentation required \$\frac{1}{2}\$ If allows \$\frac{1}{2}\$ Middle Initial \$\begin{pmatrix} \begin{pmatrix} \	anguage: (if other than English) atient of this physician? (Y or N) atient of this physician? (Y or N)	
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Certification and Consent - Signature REQUIRED

I certify that the information given on this application is current, true and correct to the best of my knowledge and I have read and agree to this statement. I understand that this application and my spouse or eligible dependent's subsequent receipt of health care services are subject to the terms of the applicable coverage document. I understand that if I enroll in a health coverage product through my employer, my employer is responsible for remitting premium payments on my behalf, or in the case of self-insured employers, my employer is responsible for paying my health care claims. I consent to any person or institution that shall have rendered health services to me or to any member of my family under the applicable coverage document to make available any photographs, records or information regarding such services to Independent Health¹. Any information received or generated by Independent Health shall be kept confidential and secure as required by applicable laws, rules, regulations or contract. I also consent to Independent Health disclosing my health information or the health information of any member of my family for Independent Health's or a provider, health plan, health care clearinghouse or other covered entity's treatment, payment or health care operations as permitted by applicable laws, rules and regulations. This consent shall remain in effect until revoked by me in writing or a maximum of 24 months from this 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 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.

X Employee/Individual Signature	Date:

1"Independent Health" means Independent Health Association, Inc. or Independent Health Benefits Corporation for members who enroll in a health coverage product through their employers or on their own. For an individual whose employer self-insures his or her health coverage, the term "Independent Health" means Independent Health Corporation, a third party administration company.

