

<input type="checkbox"/> OPTION ONE - HIP/HMO Direct		<input type="checkbox"/> Individual		<input type="checkbox"/> Individual & Spouse		No. of Adults _____		
<input type="checkbox"/> OPTION TWO - HIP Choice Plus Direct		<input type="checkbox"/> Parent & Child(ren)		<input type="checkbox"/> Family		No. of Child(ren) _____		
LAST NAME _____			FIRST NAME _____			M.I. _____		
ADDRESS _____						APT. _____		
CITY _____						STATE _____ ZIP CODE _____		
Primary Care Physician <input type="checkbox"/> Internal <input type="checkbox"/> Family Practice <input type="checkbox"/> Pediatrics						CITY _____ STATE _____ ZIP CODE _____		
Physician Name _____ Physician Number _____						CITY _____ STATE _____ ZIP CODE _____		
SOCIAL SECURITY NO. _____			Sex <input type="checkbox"/> M <input type="checkbox"/> F		Date of Birth Mo. _____ Day _____ Yr. _____		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Legally Separated/Divorced	
Telephone No. Home: (____) _____ Work: (____) _____			Date of Event Mo. _____ Day _____ Yr. _____		In case of emergency, please contact: Name: _____ Relation: _____ Telephone: _____ (H) _____ (W) _____			
E-Mail Address: _____								

Did you or any of the eligible family members have any health insurance coverage in the past 12 months? No Yes

If yes, name of insurer: _____

Policy number: _____ Coverage from _____ to _____

Which of the following describes your policy's coverage?
 Major Medical Hospitalization Medical HMO

Were you ever a member of HIP? NO YES

Please provide HIP Number: _____

If your spouse and/or dependents have other Health Insurance please provide information below:

List Below All Eligible Family Members (Last Name - if different, First Name & Social Security No.)		Sex	Med. Group Network Physician	Date of Birth			INSURANCE COMPANY	POLICY NUMBER	TYPE OF COVERAGE	EFFECTIVE FROM TO
				Mo.	Day	Yr.				
SPOUSE	NAME _____									
	SS NO. _____									
UNMARRIED ELIGIBLE CHILDREN	NAME _____									
	SS NO. _____									
• under 19 years of age	NAME _____									
	SS NO. _____									
• between the ages of 19 and 23 and full time student	NAME _____									
	SS NO. _____									

PLEASE READ CAREFULLY:

- I am applying for direct payment coverage for myself, my spouse, any eligible unmarried children under nineteen (19) year of age and unmarried children between the ages of nineteen (19) and twenty-three (23) who are full time students at an accredited educational institution and who are primary dependent on me and/or my spouse for support. I elect to enroll myself and my family members, if any, with the Medical Group/Network Physician named above.
- I understand that pre-existing conditions will not be covered, during the first 12 months of the contract. A Pre-existing Condition is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended by a duly licensed medical professional or received within the six (6) month period ending on the enrollment date. Pregnancy existing on the enrollment date of this coverage, is considered a Pre-existing Condition, for a period not to exceed ten (10) months. Genetic information may not be treated as a Pre-existing Condition in the absence of a diagnosis of the condition related to such genetic information. However, if I/we had Creditable Coverage continuously to a date not more than sixty-three (63) days before the enrollment date of this coverage, HIP will credit the time I/we were covered for the partial satisfaction of a Pre-existing Condition limitation. If I/we had Creditable Coverage for 12 months or longer, I/we will not be subject to a Pre-existing Condition limitation if the Creditable Coverage was continuous to a date not more than sixty-three (63) days before the enrollment date under this coverage.
I/we agree that after enrolled for this coverage, I/we upon request provide HIP and/or my medical group with information about any Pre-existing condition(s) and previous coverage I/we had.
Benefits for Pre-existing Conditions are not payable until we receive a copy of your Certificate of Creditable Coverage or proof of your prior coverage.
- On behalf of myself and each eligible family member, I hereby authorize all health care providers who have rendered any service to any of us, to furnish to HIP and our Medical Group/Network Physician, at any time upon request and to the extent allowed by law, all information and records relating thereto.
- My failure to pay HIP premiums on time will result in termination of coverage.
- I understand that this application is subject to acceptance and assignment of an effective date by HIP and all information furnished in this application is true and complete to the best of my knowledge.

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

All applicants must sign below. HIP CHOICE PLUS DIRECT applicants please note that the HIP CHOICE PLUS DIRECT program is provided under two separate contracts: an HIP/HMO DIRECT Contract issued by the Health Insurance Plan of Greater New York and a CHOICE PLUS DIRECT contract issued by the HIP Insurance Company of New York. Under HIP CHOICE PLUS DIRECT, you may use HMO providers or any other provider at a higher cost-sharing. Both contracts will end simultaneously if your HIP CHOICE PLUS DIRECT coverage ends.

DATE _____ SIGNATURE OF APPLICANT _____

**Your completed application must be forwarded with your check or money order to:
HIP Health Plan of New York • P.O. Box 2793 • New York, NY 10116-2793**

TO BE COMPLETED BY HIP	Date Received: _____	Effective Date: _____	Processed by: _____
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