



Healthy New York Employee Enrollment Application

PLEASE PRINT

Social Security Number

Last Name					First Name					M.I.	Sex
Street Address (Number)					Apt.	City			State	Zip Code	

Were you ever a member of HIP? NO YES
 If yes, indicate policy number: _____

Birth Date: Mo. ___ Day ___ Yr. ___ Telephone No. Home: (____) _____ Work: (____) _____
 E-Mail Address: _____

Marital Status:
 Single Widowed
 Married Divorced

Date of Event: Mo. ___ Day ___ Yr. ___

Are you covered by any other Health Insurance?
 NO YES If yes, indicate: _____

Is your spouse covered by any other Health Insurance?
 NO YES If yes, indicate: _____

Primary Care Physician Internal
 Family Practice Pediatrics

Physician Name: _____
 Physician Number: _____

Insurance Co. Name: _____
 Address: _____
 Policy No.: _____
 Effective Date: _____

* If you are applying for coverage for your spouse and or children, please list each below — see Election of Coverage for eligibility.

In case of emergency please contact: Telephone: (H) _____
 Name: _____ Relation: _____ (W) _____

Last Name (if different)	First Name	Soc. Sec. No.	Sex	Relationship	Birth Date Mo. Day Yr.	Check if over 19 or disabled	Physician Name or Number
SPOUSE:				<input type="checkbox"/> Wife <input type="checkbox"/> Husband			
ADDITIONAL DEPENDENTS: (List oldest first)				<input type="checkbox"/> Son <input type="checkbox"/> Daughter			
				<input type="checkbox"/> Son <input type="checkbox"/> Daughter			
				<input type="checkbox"/> Son <input type="checkbox"/> Daughter			
				<input type="checkbox"/> Son <input type="checkbox"/> Daughter			
				<input type="checkbox"/> Son <input type="checkbox"/> Daughter			

PLEASE INDICATE ADDITIONAL DEPENDENTS ON A DUPLICATE SHEET ELECTION OF COVERAGE AND AUTHORIZATION*

I am applying for coverage for myself, my spouse, and eligible unmarried children under 19 years of age and unmarried children between the ages of 19 and 23 who are full time students at an accredited educational institution and receive at least half of their support from me and/or my spouse. I elect to enroll myself and my family members, if any, with the Medical Group/Network Physician named above. On behalf of myself and each eligible Family Member, I hereby authorize all physicians, nurses, hospitals and other providers who or which have at any time, either before or after we became covered by HIP, provided any diagnosis, treatment or any other service to any of us, to furnish HIP and our Medical Group/Network Physician all information and records relating thereto.

I understand that pre-existing conditions will not be covered during the first 12 months of the contract. A pre-existing condition is any condition for which I/we received medical advice, diagnosis, care or treatment during the 6 months preceding my/our HIP coverage enrollment date, any condition manifesting itself in symptoms which would cause an ordinary prudent person to seek medical advice, diagnosis, care or treatment or a pregnancy existing on the HIP coverage effective date. However, if I/we had substantially similar health insurance coverage before our HIP coverage effective date and did not have a gap in coverage of more than 63 days, HIP will credit the time I/we were covered by the previous policy. I agree that after I am enrolled, I will upon request provide HIP and/or my medical group with information on pre-existing condition(s) and any previous coverage I had. This paragraph applies only to small business groups. If I am required to contribute to the premium for my coverage, I hereby authorize my employer to deduct such contributions in advance from wages due me and to remit same to HIP.

All information provided above is true and complete to the best of my knowledge. A copy of this application will be placed in my HIP medical record.

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 applicants please note that HIP CHOICE PLUS program is provided under two separate contracts: an HIP/HMO Contract issued by the Health Insurance Plan of Greater New York and CHOICE PLUS contract issued by the HIP Insurance Company of New York. Both contracts will end simultaneously if your HIP CHOICE PLUS coverage ends.

All applicants sign here: _____ Date _____

To Be Completed By Employer/Contractor Group

Name of Group		Group Number	Coverage: <input type="checkbox"/> HIP <input type="checkbox"/> HIP/HMO <input type="checkbox"/> HIP CHOICE PLUS <input type="checkbox"/> Individual <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Child <input type="checkbox"/> Family	
Requested Effective Date	Date Submitted to HIP	Approved by (Representative of Employer/Contractor)	FOR HIP USE ONLY PROCESSED BY _____ DATE _____	