

# Enrollment Application/Change Form



500 Patroon Creek Blvd.  
Albany, NY 12206-1057  
(518) 641-3700  
or  
1-800-777-2273

## EMPLOYER USE ONLY

Date Hired (MM/DD/YY) (required) \_\_\_\_\_  Full-time  Part-time (20 hours or less/week)

Date coverage is effective \_\_\_\_\_  Actively Working  COBRA  
 Retiree 65 or older  Retiree 55-65  Retiree Under 55

Date of status change \_\_\_\_\_ Employer Name \_\_\_\_\_  
 Part- to full-time  Union to non-union  Other \_\_\_\_\_

Group/Subgroup #: \_\_\_\_\_ Class #: \_\_\_\_\_

Chamber Assoc: \_\_\_\_\_ **Grp Admin Initials (required)** \_\_\_\_\_

### A. EXPLANATION (CHECK ALL THAT APPLY)

- New Hire  Open Enrollment  Loss of Coverage  Marriage  Birth  Change in Student Status  Dependent through 29
- Name/Address Change  Court Order
- COBRA—Reason:**  Left Employ/Retirement  Divorce/Legal Separation  Death of Spouse  Dependent Reached Max Age  Loss of Student Status
- Termination—Reason:**  Employment Terminated  Remove Dependents Only  Deceased  Other \_\_\_\_\_

### B. COVERAGE INFORMATION (CHECK ALL THAT APPLY)

Product Type:  HMO  EPO  HDEPO  PPO  HDPPPO  HNY

PCP Copay Amt: \$ \_\_\_\_\_ Specialist Copay Amt: \$ \_\_\_\_\_ % Coins: \_\_\_\_\_ Deduct. Amt: \$ \_\_\_\_\_

**Delta Dental Coverage**

**For employees of small groups (≤50) only. Verification of Compliance with Pediatric Essential Dental Health Benefit.**

A. Have you obtained stand-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

B. If you answered “yes,” please provide the name of the company providing the stand-alone dental coverage. \_\_\_\_\_

If you answered “no,” we will provide you coverage of the pediatric dental essential health benefit (members of small groups only).

### C. HEALTH FUNDING ACCOUNT (CHECK ALL THAT APPLY)

I am participating in a CDPHN-administered:

- Flexible Spending Account (FSA)  Health Reimbursement Arrangement (HRA)  Health Savings Account (HSA)  Not Applicable

### D. SUBSCRIBER INFO (CHECK ALL THAT APPLY)

**For HMOs only,** you and each dependent **MUST** select a Primary Care Physician (PCP). Females may also choose one OB/GYN. Also indicate if a member is a current patient and get the Physician # and Office Location from the provider directory or at [www.cdphp.com](http://www.cdphp.com). **For all other products, include copy of your HIPAA certificate. If you have Medicare Parts A and B, include a copy of your Medicare card.**

1. Last Name	First Name	M.I.	4. Telephone: Home	Work	Mobile
_____	_____	_____	_____	_____	_____
2. Street Address	Apt. #		5. E-mail Address		
_____	_____		_____		
3. City	State	ZIP	6. Employer Name		
_____	_____	_____	_____		
7. Social Security Number (Required)	Date of Birth		<b>Medical Add or Delete</b>		
_____	_____		_____ <input type="radio"/> <input type="radio"/>		
Sex: <input type="radio"/> M <input type="radio"/> F	<input type="radio"/> Disabled	<input type="radio"/> End-Stage Renal Disease		<input type="radio"/> <input type="radio"/>	
Medicare number: _____	Part A effective date: _____	Part B effective date: _____		<b>Delta Dental Add or Delete</b>	
Primary Language (optional*): Spoken: _____	Written: _____		<input type="radio"/> <input type="radio"/>		
Ethnicity (optional*): <input type="radio"/> White <input type="radio"/> Black <input type="radio"/> American Indian/Alaska Native <input type="radio"/> Asian/Pacific Islander <input type="radio"/> Hispanic/Latino <input type="radio"/> Other	<input type="radio"/> <input type="radio"/>				
Previous coverage: <input type="radio"/> Yes Previous carrier: _____	Effective from: _____		To: _____		
<b>HMO only—Physician (PCP) Last</b>	First	M.I.	Office location	Phys #	Current Patient?
_____	_____	_____	_____	_____	<input type="radio"/>
<b>OB/GYN Last</b>	First	M.I.	Office location	Phys #	Current Patient?
_____	_____	_____	_____	_____	<input type="radio"/>

\*You are not required to answer. This information is important, however, as it helps us understand the diversity of our membership.

**E. DEPENDENT INFO**

For **HMOs only**, you and each dependent **MUST** select a Primary Care Physician (PCP). Females may also choose one OB/GYN. Also indicate if a member is a current patient and get the Physician # and Office Location from the provider directory or at [www.cdphp.com](http://www.cdphp.com). **For all other products, include copy of your HIPAA certificate. If you have Medicare Parts A and B, include a copy of your Medicare card.**

8a. Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ SSN **(Required)** \_\_\_\_\_ Date of Birth \_\_\_\_\_ **Medical Add or Delete**

Rel:  Spouse  Other Sex:  M  F  Disabled  End-Stage Renal Disease

Medicare number: \_\_\_\_\_ Part A effective date: \_\_\_\_\_ Part B effective date: \_\_\_\_\_ **Delta Dental Add or Delete**

Primary Language (optional\*): Spoken: \_\_\_\_\_ Written: \_\_\_\_\_ **Delta Dental Add or Delete**

Ethnicity (optional\*):  White  Black  American Indian/Alaska Native  Asian/Pacific Islander  Hispanic/Latino  Other

Previous coverage:  Yes Previous carrier: \_\_\_\_\_ Effective from: \_\_\_\_\_ To: \_\_\_\_\_

HMO only—Physician (PCP) Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ Office location \_\_\_\_\_ Phys # \_\_\_\_\_ Current Patient?

OB/GYN Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ Office location \_\_\_\_\_ Phys # \_\_\_\_\_ Current Patient?

8b. Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ SSN **(Required)** \_\_\_\_\_ Date of Birth \_\_\_\_\_ **Medical Add or Delete**

Rel:  Son  Daughter  Full-time student?  Disabled  End-Stage Renal Disease

Medicare number: \_\_\_\_\_ Part A effective date: \_\_\_\_\_ Part B effective date: \_\_\_\_\_ **Delta Dental Add or Delete**

Primary Language (optional\*): Spoken: \_\_\_\_\_ Written: \_\_\_\_\_ **Delta Dental Add or Delete**

Ethnicity (optional\*):  White  Black  American Indian/Alaska Native  Asian/Pacific Islander  Hispanic/Latino  Other

School name (if student) \_\_\_\_\_ Expected date of graduation \_\_\_\_\_ School address (City, State, ZIP) \_\_\_\_\_

Previous coverage:  Yes Previous carrier: \_\_\_\_\_ Effective from: \_\_\_\_\_ To: \_\_\_\_\_

HMO only—Physician (PCP) Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ Office location \_\_\_\_\_ Phys # \_\_\_\_\_ Current Patient?

OB/GYN Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ Office location \_\_\_\_\_ Phys # \_\_\_\_\_ Current Patient?

8c. Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ SSN **(Required)** \_\_\_\_\_ Date of Birth \_\_\_\_\_ **Medical Add or Delete**

Rel:  Son  Daughter  Full-time student?  Disabled  End-Stage Renal Disease

Medicare number: \_\_\_\_\_ Part A effective date: \_\_\_\_\_ Part B effective date: \_\_\_\_\_ **Delta Dental Add or Delete**

Primary Language (optional\*): Spoken: \_\_\_\_\_ Written: \_\_\_\_\_ **Delta Dental Add or Delete**

Ethnicity (optional\*):  White  Black  American Indian/Alaska Native  Asian/Pacific Islander  Hispanic/Latino  Other

School name (if student) \_\_\_\_\_ Expected date of graduation \_\_\_\_\_ School address (City, State, ZIP) \_\_\_\_\_

Previous coverage:  Yes Previous carrier: \_\_\_\_\_ Effective from: \_\_\_\_\_ To: \_\_\_\_\_

HMO only—Physician (PCP) Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ Office location \_\_\_\_\_ Phys # \_\_\_\_\_ Current Patient?

OB/GYN Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ Office location \_\_\_\_\_ Phys # \_\_\_\_\_ Current Patient?

**Note: Make sure you sign and date the application on the next page.**

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**E. DEPENDENT INFO *Cont'd***

8d. Last	First	M.I.	SSN <i>(Required)</i>	Date of Birth	Medical Add or Delete
_____					<input type="radio"/> <input type="radio"/>
Rel: <input type="radio"/> Son <input type="radio"/> Daughter	<input type="radio"/> Full-time student?	<input type="radio"/> Disabled	<input type="radio"/> End-Stage Renal Disease		<input type="radio"/> <input type="radio"/>
Medicare number: _____	Part A effective date: _____	Part B effective date: _____			Delta Dental Add or Delete
Primary Language <i>(optional*)</i> : Spoken: _____	Written: _____				<input type="radio"/> <input type="radio"/>
Ethnicity <i>(optional*)</i> : <input type="radio"/> White <input type="radio"/> Black <input type="radio"/> American Indian/Alaska Native <input type="radio"/> Asian/Pacific Islander <input type="radio"/> Hispanic/Latino <input type="radio"/> Other					<input type="radio"/> <input type="radio"/>
School name <i>(if student)</i>	Expected date of graduation	School address <i>(City, State, ZIP)</i>			
_____					
Previous coverage: <input type="radio"/> Yes	Previous carrier: _____	Effective from: _____	To: _____		
HMO only—Physician (PCP) Last	First	M.I.	Office location	Phys #	Current Patient?
_____					<input type="radio"/>
OB/GYN Last	First	M.I.	Office location	Phys #	Current Patient?
_____					<input type="radio"/>

**F. OTHER INSURANCE**

Do you, your spouse, or any of your dependents have any other medical insurance that will be maintained in addition to CDPHP?  Yes: *If yes, complete below.*  No

9. Policyholder name	Policy #	Insurance carrier	Employer name
_____	_____	_____	_____
Date of birth: _____	Address: _____		
Effective date: _____	Coverage type: <input type="radio"/> Hospital <input type="radio"/> Medical <input type="radio"/> Drug <input type="radio"/> Dental <input type="radio"/> Vision		
Covered Individuals— <i>Check all that apply</i>	<input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Dependents		

**G. SIGNATURE: AGREEMENT:** I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge and that I have read the important information on the last page of this form.

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 \$5,000 and the stated value of the claim for each such violation.

10. Applicant's Signature: \_\_\_\_\_ 11. Date: \_\_\_\_\_

**IMPORTANT INFORMATION**

Failure to complete any sections will result in a processing delay of your application, member ID cards and, claims payment. Failure by your employer to complete the employer section will also result in a delay.

If you should have any questions about this Enrollment Application/Change Form, please call the CDPHP® member services department at (518) 641-3700 or 1-800-777-2273. Thank you for choosing CDPHP for your health care coverage.

Your signature on this application hereby affirms the following:

On behalf of myself and any dependents listed, I hereby apply for coverage under the Master Group Contract (health and/or dental, as the case may be) issued to my employer by Capital District Physicians' Health Plan, Inc. and/or CDPHP Universal Benefits® Inc. (CDPHP UBI) and/or Delta Dental of New York, Inc.

I understand that the benefits for which I (we) will be eligible are in accordance with those described in the Master Group Contract and any attached riders. I further understand that for HMO benefits provided by Capital District Physicians' Health Plan, Inc., except for emergencies, covered services must be obtained through a participating physician (unless otherwise noted in rider) or in a participating hospital (unless otherwise noted in rider) when admitted or referred by a participating physician (unless otherwise noted in rider), and also that certain services may require a copayment (unless otherwise noted in rider) by me (or my dependents) directly to the provider of such services.

I hereby permit my employer to deduct the necessary Health Services Fees, if any, from my wages or salary, with the understanding that the employer acts as my agent in all dealings with CDPHP and/or Delta Dental of New York, Inc., and that all acts performed by the employer and all notices given to the employer in such dealings are binding upon me, as not prohibited by statute or regulation.

I understand that unresolved grievances are subject to the procedure specified in the Master Group Contract.

**CDPHP COMPANIES**

Capital District Physicians' Health Plan, Inc.  
CDPHP Universal Benefits® Inc.  
Capital District Physicians' Healthcare Network, Inc.

Delta Dental Service Plans are underwritten and administered by Delta Dental of New York, Inc.



Delta Dental of New York  
One Delta Drive  
Mechanicsburg, PA 17055  
1-800-932-0783  
TTY/TDD 1-888-373-3582  
[www.deltadentalins.com](http://www.deltadentalins.com)

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