



Enrollment Application/Change Form

500 Patroon Creek Blvd.
Albany, NY 12206-1057
(518) 641-5000 or 1-800-993-7299

EXPLANATION	Check all that apply	Explanation and Effective Date	EMPLOYER USE
	<input type="checkbox"/> New Enrollment <input type="checkbox"/> Name Change <input type="checkbox"/> Cobra Continuation <input type="checkbox"/> Add Dependent <input type="checkbox"/> Termination <input type="checkbox"/> Remove Dependent Only	<input type="checkbox"/> New Hire <input type="checkbox"/> Qualifying Event/Reason: _____ <input type="checkbox"/> Loss of Coverage (include proof—HIPAA Cert.) <input type="checkbox"/> Effective Date: _____	<input type="checkbox"/> Open Enrollment <input type="checkbox"/> Employee Terminated <input type="checkbox"/> Moved Out of Area <input type="checkbox"/> Open Enrollment—Transferred to another plan <input type="checkbox"/> Dissatisfaction <input type="checkbox"/> Cost <input type="checkbox"/> Spouse's Coverage <input type="checkbox"/> Other: _____ Effective Date: _____

Check Type of Coverage: AvidCare (CDPHP HMO) AdaptaCare (CDPHP UBI POS)

SUBSCRIBER	1. First Name				M.I.				Last Name				4. Your Social Security #				6a. Employer Name			
	2. Street Address				Apt. #				5. Telephone:				6b. Chamber/Association							
	3. City				State				County				Zip Code				7. Primary language if other than English:			

8. MEMBER INFORMATION	Add	Delete	Name: Indicate different last names, if applicable. List oldest dependents first. First M.I. Last	Date of Birth (mm/dd/yy)	Relationship	Social Security Number	Medicare A & B* Effective Date *Copy of Medicare Card must be attached.	Full-Time Student	You, and each dependent, must select a Primary Care Physician (PCP). Females may also choose one OB/GYN. For all selections, indicate if you are a current patient and the Physician # and office location from the provider directory.		Physician Number	if current patient
									Physician First and Last Name	Office Location		
<input type="checkbox"/>	<input type="checkbox"/>	00	Applicant	/ /	Self <input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> A / / <input type="checkbox"/> B / /		PCP OB/GYN			<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	01		/ /	<input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Other		<input type="checkbox"/> A / / <input type="checkbox"/> B / /		PCP OB/GYN			<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	02		/ /	<input type="checkbox"/> Son <input type="checkbox"/> Daughter		<input type="checkbox"/> A / / <input type="checkbox"/> B / /	<input type="checkbox"/> Yes <input type="checkbox"/> No	PCP OB/GYN			<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	03		/ /	<input type="checkbox"/> Son <input type="checkbox"/> Daughter		<input type="checkbox"/> A / / <input type="checkbox"/> B / /	<input type="checkbox"/> Yes <input type="checkbox"/> No	PCP OB/GYN			<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	04		/ /	<input type="checkbox"/> Son <input type="checkbox"/> Daughter		<input type="checkbox"/> A / / <input type="checkbox"/> B / /	<input type="checkbox"/> Yes <input type="checkbox"/> No	PCP OB/GYN			<input type="checkbox"/>

9. DEPENDENT	Full-time college students age 19 and over:		Expected Date of Graduation:		10. OTHER INSURANCE	
	School Name and Address:				Other Coverage—Do you, your spouse, or any of your dependents have any other medical insurance that will be maintained in addition to CDPHP? <input type="checkbox"/> Yes <i>If yes, complete below.</i> <input type="checkbox"/> No	
Do you have a disabled dependent beyond age 19? <input type="checkbox"/> No <input type="checkbox"/> Yes (list name[s]):				Policyholder name: Relationship: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child		
				Social Security Number: Date of Birth: / /		
				Insurance Carrier: Policy #: Effective Date:		

11. 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 reverse side of this form.	
	Applicant's Signature	Date
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.		
Address: Telephone: Covered Individuals:		
Plan Type: Coverage Type: <input type="checkbox"/> Self Only <input type="checkbox"/> Self & Family <input type="checkbox"/> Hospital <input type="checkbox"/> Medical <input type="checkbox"/> Drug <input type="checkbox"/> Dental <input type="checkbox"/> Vision		



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Check Type of Coverage: AvidCare (CDPHP HMO) AdaptaCare (CDPHP UBI POS)

SUBSCRIBER	1. First Name				M.I.	Last Name				4. Your Social Security #				6a. Employer Name					
	2. Street Address				Apt. #				5. Telephone:				6b. Chamber/Association						
	3. City				State				County				Zip Code				7. Primary language if other than English:		

8. MEMBER INFORMATION	Add	Delete	Name: Indicate different last names, if applicable. List oldest dependents first. First M.I. Last	Date of Birth (mm/dd/yy)	Relationship	Social Security Number	Medicare A & B* Effective Date *Copy of Medicare Card must be attached.	Full-Time Student	You, and each dependent, must select a Primary Care Physician (PCP). Females may also choose one OB/GYN. For all selections, indicate if you are a current patient and the Physician # and office location from the provider directory.		Physician Number	if current patient
									Physician First and Last Name	Office Location		
<input type="checkbox"/>	<input type="checkbox"/>	00	Applicant	/ /	Self <input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> A / / <input type="checkbox"/> B / /		PCP OB/GYN			<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	01		/ /	<input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Other		<input type="checkbox"/> A / / <input type="checkbox"/> B / /		PCP OB/GYN			<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	02		/ /	<input type="checkbox"/> Son <input type="checkbox"/> Daughter		<input type="checkbox"/> A / / <input type="checkbox"/> B / /	<input type="checkbox"/> Yes <input type="checkbox"/> No	PCP OB/GYN			<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	03		/ /	<input type="checkbox"/> Son <input type="checkbox"/> Daughter		<input type="checkbox"/> A / / <input type="checkbox"/> B / /	<input type="checkbox"/> Yes <input type="checkbox"/> No	PCP OB/GYN			<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	04		/ /	<input type="checkbox"/> Son <input type="checkbox"/> Daughter		<input type="checkbox"/> A / / <input type="checkbox"/> B / /	<input type="checkbox"/> Yes <input type="checkbox"/> No	PCP OB/GYN			<input type="checkbox"/>

9. DEPENDENT	Full-time college students age 19 and over:		Expected Date of Graduation:		10. OTHER INSURANCE
	School Name and Address:				
Do you have a disabled dependent beyond age 19? <input type="checkbox"/> No <input type="checkbox"/> Yes (list name[s]): _____					Insurance Carrier: _____ Policy #: _____ Effective Date: _____ Address: _____ Employer Name: _____ Telephone: _____ Covered Individuals: _____

11. SIGNATURE	AGREEMENT
Applicant's Signature _____ Date _____	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 reverse side 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.



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Check Type of Coverage: AvidCare (CDPHP HMO) AdaptaCare (CDPHP UBI POS)

SUBSCRIBER	1. First Name _____ M.I. _____ Last Name _____	4. Your Social Security # _____	6a. Employer Name _____
	2. Street Address _____ Apt. # _____	5. Telephone: Home: () - _____	6b. Chamber/Association _____
	3. City _____ State _____ County _____ Zip Code _____	Work: () - _____	7. Primary language if other than English: _____

8. MEMBER INFORMATION	Add	Delete	Name: Indicate different last names, if applicable. List oldest dependents first.	Date of Birth (mm/dd/yy)	Relationship	Social Security Number	Medicare A & B* Effective Date	Full-Time Student	You, and each dependent, must select a Primary Care Physician (PCP). Females may also choose one OB/GYN. For all selections, indicate if you are a current patient and the Physician # and office location from the provider directory.	Physician First and Last Name	Office Location	Physician Number	if current patient
	<input type="checkbox"/>	<input type="checkbox"/>	First M.I. Last	(mm/dd/yy)	Self <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Other		Effective Date <i>*Copy of Medicare Card must be attached.</i>		PCP OB/GYN				
	<input type="checkbox"/>	<input type="checkbox"/>	00 Applicant	/ /			<input type="checkbox"/> A / / <input type="checkbox"/> B / /		PCP OB/GYN				<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	01	/ /			<input type="checkbox"/> A / / <input type="checkbox"/> B / /		PCP OB/GYN				<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	02	/ /	<input type="checkbox"/> Son <input type="checkbox"/> Daughter		<input type="checkbox"/> A / / <input type="checkbox"/> B / /	<input type="checkbox"/> Yes <input type="checkbox"/> No	PCP OB/GYN				<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	03	/ /	<input type="checkbox"/> Son <input type="checkbox"/> Daughter		<input type="checkbox"/> A / / <input type="checkbox"/> B / /	<input type="checkbox"/> Yes <input type="checkbox"/> No	PCP OB/GYN				<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	04	/ /	<input type="checkbox"/> Son <input type="checkbox"/> Daughter		<input type="checkbox"/> A / / <input type="checkbox"/> B / /	<input type="checkbox"/> Yes <input type="checkbox"/> No	PCP OB/GYN				<input type="checkbox"/>

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	School Name and Address: _____	
Do you have a disabled dependent beyond age 19? <input type="checkbox"/> No <input type="checkbox"/> Yes (list name[s]): _____	Policyholder name: _____ Relationship: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	
	Social Security Number: _____ Date of Birth: _____ / /	
	Insurance Carrier: _____ Policy #: _____ Effective Date: _____	
	Address: _____ Employer Name: _____	
	Telephone: _____ Covered Individuals: _____	
	Plan Type: <input type="checkbox"/> Self Only <input type="checkbox"/> Self & Family	Coverage Type: <input type="checkbox"/> Hospital <input type="checkbox"/> Medical <input type="checkbox"/> Drug <input type="checkbox"/> Dental <input type="checkbox"/> Vision

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	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.
Applicant's Signature _____ Date _____	

IMPORTANT

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 Marketing Department at (518) 641-5000 or 1-800-993-7299. Thank you for choosing CDPHP for your health care coverage.

Your signature on the reverse of this application hereby affirms the following:

On behalf of myself and any dependents listed, I hereby apply for coverage under the Master Group Contract issued to my employer by Capital District Physicians' Health Plan, Inc. and/or CDPHP Universal Benefits, 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 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.