



# Enrollment Application/ Change Form



CDPHP Universal Benefits, Inc.  
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: _____	Date hired ____ / ____ / ____ Date of status change ____ / ____ / ____ <input type="checkbox"/> Part- to full-time <input type="checkbox"/> Temporary to permanent <input type="checkbox"/> Union to non-union <input type="checkbox"/> Other _____ Date coverage is to be effective: _____ Group/Division #: _____ Employee Status: A. <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time (hours per week) _____ B. <input type="checkbox"/> Active <input type="checkbox"/> Retiree <input type="checkbox"/> Salaried <input type="checkbox"/> Union <input type="checkbox"/> Other Group Administrator Initials (required) _____

**■ Fox First EPO**

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.	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	Previous Health Care Coverage Effective Dates (Include copy of HIPAA Cert.)
	<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 / /	
<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 / /		<input type="checkbox"/> Yes Dates: / / to / / <input type="checkbox"/> No Previous Carrier: <input type="checkbox"/> No
<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	<input type="checkbox"/> Yes Dates: / / to / / <input type="checkbox"/> No Previous Carrier: <input type="checkbox"/> No
<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	<input type="checkbox"/> Yes Dates: / / to / / <input type="checkbox"/> No Previous Carrier: <input type="checkbox"/> No
<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	<input type="checkbox"/> Yes Dates: / / to / / <input type="checkbox"/> No Previous Carrier: <input type="checkbox"/> No

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 If yes, complete below. <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:
			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

**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.**

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 \_\_\_\_\_

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<b>EXPLANATION</b>	<b>Check all that apply</b> <input type="checkbox"/> New Enrollment <input type="checkbox"/> Name Change <input type="checkbox"/> Cobra Continuation <input type="checkbox"/> Add Dependent	<b>Explanation and Effective Date</b> <input type="checkbox"/> New Hire <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Qualifying Event/Reason: _____ <input type="checkbox"/> Loss of Coverage (include proof—HIPAA Cert.) <input type="checkbox"/> Effective Date _____	<b>EMPLOYER USE</b>
	<input type="checkbox"/> Termination <input type="checkbox"/> Remove Dependent Only	<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: _____	

Date hired \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Date of status change \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Part- to full-time  Temporary to permanent  
 Union to non-union  Other \_\_\_\_\_  
 Date coverage is to be effective: \_\_\_\_\_  
 Group/Division #: \_\_\_\_\_  
 Employee Status: A.  Full-time  Part-time (hours per week) \_\_\_\_\_  
 B.  Active  Retiree  Salaried  Union  Other  
 Group Administrator Initials (required) \_\_\_\_\_

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<b>SUBSCRIBER</b>	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. 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	Previous Health Care Coverage Effective Dates (Include copy of HIPAA Cert.)
	<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 / /	
<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 / /		<input type="checkbox"/> Yes Dates: / / to / / Previous Carrier: <input type="checkbox"/> No
<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	<input type="checkbox"/> Yes Dates: / / to / / Previous Carrier: <input type="checkbox"/> No
<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	<input type="checkbox"/> Yes Dates: / / to / / Previous Carrier: <input type="checkbox"/> No
<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	<input type="checkbox"/> Yes Dates: / / to / / Previous Carrier: <input type="checkbox"/> No

<b>9. DEPENDENT</b>	Full-time college students age 19 and over: School Name and Address: _____ Expected Date of Graduation: _____	<b>10. OTHER INSURANCE</b>	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 If yes, complete below. <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: _____	
<b>11. SIGNATURE</b>	<b>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.</b> 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: _____ 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
	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 Universal Benefits, Inc. (CDPHP UBI) marketing department at (518) 641-5000 or 1-800-993-7299. Thank you for choosing CDPHP UBI 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 CDPHP UBI.

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

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 UBI, 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.

Note: Your CDPHP UBI coverage may have a pre-existing condition clause. Please consult your benefit materials or check with your personnel office for more specific information.