Independent Health

Enrollment Application/Change Form

Please clearly **PRINT** all information

P.O. Box 710, Buffalo, NY 14231-0710 independenthealth.com

Employer Admin. Initials:	Date:

Confidential

For IHA Use Only
ID:
DOB:
Account:

To avoid a delay in your health insurance coverage, please be sure ALL REQUIRED FIELDS ARE COMPLETED (noted with an *)

What type of insurance are you applying for (select one)?

☐ Employer Group – actively employed ☐ Cobra ☐ Individual (application must include payment)

A Coverage Information

Grand Island Chamber of Commerce

***Name of Employer** *(not needed for individuals not associated with employer group)*

24630

***Account Number** Sub Account *(if applicable)* ***Plan Name**

***Effective Date** *(date the coverage for this applicant should be effective)*

Failure to include a date in this field may result in a delay in your coverage

Employee ID/Division/Union/Class *(if applicable)*

B Qualifying Event Information *(complete only one section)*

☐ **Enroll/Add Coverage** *(enter date and select reason below)* **Date of Qualifying Event:** ____/____/____ (ex: date of hire)

Check One:

☐ Open Enrollment ☐ New Hire § ☐ Newborn § ☐ Marriage § ☐ Relocated/transfer§

☐ Adoption/Guardianship† ☐ Involuntary Loss of Coverage § ☐ Change in Employment Status § ☐ Domestic Partner‡ ☐ Enrolling Cobra coverage

† Supporting documentation required ‡ *If allowed by plan; supporting documentation required* § *Must include date of qualifying event above*

☐ **Disenroll/Cancel Coverage** *(enter date and select reason below)* **Effective date of cancellation:** ____/____/____

Check One:

☐ Terminate Employment ☐ Deceased ☐ Dependent Max age reached ☐ Personal Reasons/Divorced ☐ †Moved out of area

☐ No longer eligible ☐ Nonpayment ☐ Other coverage ☐ Layoff/Strike

☐ Cancel coverage for entire family ☐ Cancel coverage for all dependents only ☐ Cancel coverage for the following dependents only:

☐ **Change(s) to existing plan** *(enter date and select reason below)* **Effective date of change** ____/____/____

Check One:

☐ Address ☐ Phone No. ☐ Marital status ☐ Last Name ☐ New Employment type*

***If new employment type check one box below:**

☐ Active ☐ COBRA ☐ Inactive ☐ Surviving Insured ☐ TEFRA/DEFRA ☐ Retired

Check here if employee is changing to retired status

C Employee/Individual Information *(Be sure all required fields are completed)*

Social Security Number and/or HICN (Medicare ID) must be provided for the employee/individual and for ALL dependents. Any applications submitted without an SSN for each employee/individual may be delayed or denied. Please see your employer's Benefit Administrator if you are unable to supply an SSN for each applicant.

***Employee/Individual SSN or HICN:**

***Employee Status if Applicable**

***Employee/Individual Last Name** ***First Name** Middle Initial

☐ A (active) ☐ R (Retired) ☐ C (Cobra)

***Address** *(PO Box not accepted)* Apartment/Suite/Building:

***City** ***State** ***Zip** ***Date of Birth (MM/DD/YYYY)**

***Gender** *(M or F)* ***Primary Phone No.** *(include area code)* Secondary Phone No. *(include area code)* Cell Phone No. *(include area code)*

( ) ( ) ( )

***Email address:** Primary Language: (if other than English)

Primary Care Physician *(refer to Independent Health Provider Directory at independenthealth.com)*

Provider ID Provider Name Are you a current patient of this physician? *(Y or N)* OB/GYN *(if applicable)*

Other Health Insurance *Indicate if you or anyone else on this application will have other health insurance while enrolled with Independent Health*

Insurance Carrier Name Policy No. Name of Insured Are you or anyone included on this application covered by Medicare? *(Y or N)* Effective Date

***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**

If you answered "yes," please provide the name of the company issuing the stand-alone dental coverage.

If you answered "no," we will provide you coverage of the pediatric dental essential health benefit. Additional premium may apply.

Please complete reverse of application including dependent information (if applicable) and applicant signature (required)

OA-6431-6350-REV-1013
PR1013-150M

*Employee/Individual Social Security Number or HICN

Dependent #1

*Dependent SSN or HICN:

*Relationship to Employee/Individual

☐ Spouse ☐ Child ☐ Grandchild ‡ ☐ Legal ward † ☐ Domestic Partner ☐ Other_____ please specify

*Dependent/Spouse Last Name: *First Name Middle Initial *Date of Birth (MM/DD/YYYY)

*Gender *(M or F)* *Primary Phone No. *(include area code)* ( ) Secondary Phone No. *(include area code)* ( ) Cell Phone No. *(include area code)* ( )

*Email address: Primary Language: (if other than English)

Primary Care Physician *(refer to Independent Health Provider Directory)*

Provider ID Provider Name Are you a current patient of this physician? *(Y or N)* OB/GYN *(if applicable)*

Dependent #2

*Dependent SSN or HICN:

*Relationship to Employee/Individual

☐ Spouse ☐ Child ☐ Grandchild ‡ ☐ Legal ward † ☐ Domestic Partner ☐ Other_____ please specify

*Dependent/Spouse Last Name: *First Name Middle Initial *Date of Birth (MM/DD/YYYY)

*Gender *(M or F)* *Primary Phone No. *(include area code)* ( ) Secondary Phone No. *(include area code)* ( ) Cell Phone No. *(include area code)* ( )

*Email address: Primary Language: (if other than English)

Primary Care Physician *(refer to Independent Health Provider Directory)*

Provider ID Provider Name Are you a current patient of this physician? *(Y or N)* OB/GYN *(if applicable)*

Dependent #3

*Dependent SSN or HICN:

*Relationship to Employee/Individual

☐ Spouse ☐ Child ☐ Grandchild ‡ ☐ Legal ward † ☐ Domestic Partner ☐ Other_____ please specify

*Dependent/Spouse Last Name: *First Name Middle Initial *Date of Birth (MM/DD/YYYY)

*Gender *(M or F)* *Primary Phone No. *(include area code)* ( ) Secondary Phone No. *(include area code)* ( ) Cell Phone No. *(include area code)* ( )

*Email address: Primary Language: (if other than English)

Primary Care Physician *(refer to Independent Health Provider Directory)*

Provider ID Provider Name Are you a current patient of this physician? *(Y or N)* OB/GYN *(if applicable)*

Certification and Consent – Signature REQUIRED

I certify that the information given on this application is current, true and correct to the best of my knowledge and I have read and agree to this statement. I understand that this application and my spouse or eligible dependent's subsequent receipt of health care services are subject to the terms of the applicable coverage document. I understand that if I enroll in a health coverage product through my employer, my employer is responsible for remitting premium payments on my behalf, or in the case of self-insured employers, my employer is responsible for paying my health care claims.

I consent to any person or institution that shall have rendered health services to me or to any member of my family under the applicable coverage document to make available any photographs, records or information regarding such services to Independent Health[1]. Any information received or generated by Independent Health shall be kept confidential and secure as required by applicable laws, rules, regulations or contract. I also consent to Independent Health disclosing my health information or the health information of any member of my family for Independent Health's or a provider, health plan, health care clearinghouse or other covered entity's treatment, payment or health care operations as permitted by applicable laws, rules and regulations. This consent shall remain in effect until revoked by me in writing or a maximum of 24 months from this authorization.

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 five thousand dollars and the stated value of the claim for each such violation.

X **Employee/Individual Signature** _____ **Date:** _____

[1]"Independent Health" means Independent Health Association, Inc. or Independent Health Benefits Corporation for members who enroll in a health coverage product through their employers or on their own. For an individual whose employer self-insures his or her health coverage, the term "Independent Health" means Independent Health Corporation, a third party administration company.

For additional dependents please attach an additional copy of page 2 (this side) of this application