NY HA
NY HEALTH ALLIANCE
NEW YORK'S HEALTH INSURANCE EXCHANGE

UPSTATE REGION: NEW BUSINESS ENROLLMENT / CHANGE FORM

Rate: $ *Broker Use Only*

NYHA #:

A. EMPLOYEE INFORMATION

Employee Name (Last) (First) (Middle)

Home Phone ( ) Work Phone ( )

Date of Hire Month Day Year

Address (Street No.) (City) (State) (Zip)

NEW EMPLOYEE / CHANGE INFORMATION

- ☐ Initial Enrollment
- ☐ Renewal
- ☐ Status Change
- ☐ Active Medicare Participation
- ☐ Qualifying Event**

Check One:

- ☐ New Hire
- ☐ Age 29 Mandate
- ☐ COBRA:
  - ○ Direct Bill
  - ○ Group Bill

Effective Date: _____

B. OTHER INSURANCE

Do you or any of your dependents have coverage under any other medical plan? ☐ YES ☐ NO

If yes, provide the information. — here

Were you covered by another medical/hospital/dental plan within the last 12 months? ☐ YES ☐ NO If yes, provide the information in **Section E.**

Name of Insured | Employer Name: | Tel: | ☐ Individual Coverage ☐ Family Coverage

Health Insurer Name | Dental Insurer Name

Are you or any of your dependents eligible for Medicare or Medicaid? ☐ YES ☐ NO

C. TYPE OF COVERAGE (Please select one of the following)

MVP HealthCare (EPO & PPO)

Non Standard Plans

- ☐ Platinum 1
- ☐ Platinum 4
- ☐ Gold 1
- ☐ Gold 3
- ☐ Gold 4
- ☐ Silver 1
- ☐ Silver 7
- ☐ Bronze 1
- ☐ Bronze 6 HDHP
- ☐ PPO Gold
- ☐ PPO Silver

Colonial Supplemental Insurance

- ☐ Medical Bridge $1000 Benefit
- ☐ Medical Bridge $2000 Benefit

GUARDIAN

DENTAL DHMO	PPO VP
☐ MDG U20M5 V	☐ 1000 Max
☐ MDG U40M5 V	☐ 1500 Max
☐ MDG U20M5 W	☐ 2000 Max
☐ MDG U40M5 W	☐ 2500 Max

Shelter Point

- ☐ Hospital Cash $165

Davis Vision

- ☐ Option 1
- ☐ Option 2

GVS Vision & Hearing

- ☐ Option 1
- ☐ Option 2
- ☐ Option 3

STATUS CHANGE

- ☐ Add Dependent
- ☐ Remove Dependent
- ☐ Name Change
- ☐ Address Change
- ☐ Employee Termination
- ☐ Loss of Coverage
- ☐ Age 29 Mandate
- ☐ COBRA Exp. Date: _____

Date: _____

Reason: _____

D. EMPLOYER INFORMATION

Employer Name:_____ Telephone #:_____ Is employee currently working at least 20 hours per week? ☐ Yes ☐ No

E. ENROLLMENT INFORMATION

Name (Indicate If Last Name Is Different) (Last Name) (First) (MI)	*Birth Date Mo / Day / Yr*	*Social Security No.*	*Sex*	*Relationship Code*	*Former Health Insurance Coverage (Previous 12 months)*	*Date of Former Coverage FROM - TO* Mo. Yr. Mo. Yr.	*Primary Care Physician ID # or Name (Choose for each family member)*	*✓ if current Patient*
Employee		- -						
Spouse		- -						
Dependent		- -						
Dependent		- -						
Dependent		- -						
Dependent		- -						

Relationship Codes: 001 Spouse 002 Child 003 Student** 004 Disabled** 005 Stepchild** 006 Legal Guardianship** 007 Domestic Partner** **Documentation Required

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 civil penalty not to exceed five thousand dollars, and the stated value of the claim for each violation.

Employee/Applicant Signature Date

EMPLOYER AUTHORIZATION

This form must be signed and dated by an authorized company employee. By signing this form, I verify that to the best of my knowledge, the information contained, herein, is true and complete. I also certify that the person(s) are eligible employees (or dependents) and work for the employer identified on this form.

Signature-Authorized Company Representative

Print Name/Title Date