Empire BlueCross BlueShield
PO Box 1407, Church Street Station
New York, NY 10008-1407

HMO

Direct Payment Application

INSTRUCTIONS

Please take the time to carefully complete all sections of this application that pertain to you. Incomplete and unsigned applications cannot be processed and may result in a later coverage effective date. DO NOT send payment with this form.

You may submit this application if you do not have comparable coverage available through an employer group or if you are not enrolled on any other health insurance contract. You may use this application to apply for new enrollment, a status change or a transfer of coverage.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

Please type or print firmly with blue or black ballpoint pen.

Empire BlueCross BlueShield is licensed to operate in a 28 county area of eastern New York State. You must reside in one of these counties to be eligible to enroll: Albany, Clinton, Bronx, Columbia, Delaware, Dutchess, Essex, Fulton, Greene, Kings, Montgomery, Nassau, New York, Orange, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington, Westchester. PO Boxes are not accepted as a valid address.

Section 1-9: Please tell us about yourself and your family.

Section 11: Your choice of contract must be appropriate.

TYPE OF COVERAGE:

To be Classified as an Individual

- You are unmarried.
- You are married without dependent children and your spouse is covered by Medicare or another benefit plan that does not provide dependent coverage for you.

To be Classified as a Applicant/Spouse

- You are married without dependent children.

To be Classified as a Parent/Child(ren)

- You are single and have one or more dependent children.

To be Classified as a Family

- You are married and have one or more dependent children. (An Applicant and Spouse enrolling with one or more dependent children must apply for a family contract.)

NOTE: Same sex spouses must have entered into a marriage legally recognized in the jurisdiction in which it is performed.

DEPENDENT CHILDREN:

- An eligible dependent is the natural or adopted child or stepchild of you or your spouse and any proposed adoptive child who is dependent on you pending finalization of the adoption, to age 26. Over-age disabled dependent children may also qualify. See your policy for details. Dependents are also eligible for coverage from ages 26 through 29 without regard to financial dependence, if the dependent is: unmarried, not insured by or eligible for coverage under an employer sponsored health benefit plan covering them as an employee or member, whether insured or self-insured, AND lives, works or resides in New York State. Coverage of each child lasts until the end of the month in which the child no longer meets eligibility conditions.

Section 13: Employment status must be completed in full for applicant and spouse.

Section 15: Please be as specific as possible in completing this section. Your response will help us to determine whether a pre-existing condition waiting period or portability of coverage applies to you.

Signature: Your signature, and that of your spouse, must be provided and complete.

NOTE: Please do not send payment with this form. If this application is accepted, we will issue a bill as well as a contract and identification card(s). If issued, the contract(s) will be effective on the date indicated on the identification card(s) if payment of the bill amount is received by Empire BlueCross BlueShield according to the billing notice sent to you.

Use the envelope you received with this application to return your completed application to Empire BlueCross BlueShield. If you have any questions about this program or need assistance in completing this application, please call our Dedicated Service Area at 1-800-261-5962. We will be glad to help you.

Services provided by Empire HealthChoice HMO, Inc., a licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

ENR 0131 9/10

DIRECT PAYMENT APPLICATION

FOR OFFICE USE ONLY

1. SOCIAL SECURITY NUMBER	HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER

2. APPLICANT'S LAST NAME	FIRST NAME	MIDDLE INITIAL

3A. HOME ADDRESS	Apt#

CITY	STATE	ZIP CODE	CARE OF

3B. MAILING ADDRESS, if different from HOME ADDRESS	Apt#

4. MALE ❒ FEMALE ❒	5. DATE OF BIRTH	6. SINGLE ❒ MARRIED ❒ SEPARATED ❒ DIVORCED ❒ WIDOWED ❒	7A. DATE OF MARRIAGE

7B. PLACE OF MARRIAGE*	CITY	STATE	ZIP CODE	COUNTRY

*NOTE: Marriage must have been entered into in a jurisdiction that recognizes its validity.

8A. **Please tell us about you, your spouse and dependent children.** If you are applying for coverage for them, you must complete this section. If additional space is required, please provide the information requested below on a separate sheet of paper and attach it to the application.

	LAST NAME, FIRST NAME, M.I.	SEX	DATE OF BIRTH	SOCIAL SECURITY NO.	PCP NAME*	PCP NO.*	CURRENT PATIENT
APPLICANT		❒ M ❒ F					Y ❒ N ❒
SPOUSE		❒ M ❒ F					Y ❒ N ❒
CHILD		❒ M ❒ F					Y ❒ N ❒
CHILD		❒ M ❒ F					Y ❒ N ❒
CHILD		❒ M ❒ F					Y ❒ N ❒
CHILD		❒ M ❒ F					Y ❒ N ❒

8B. Applicants and their spouses must be legally domiciled in one of the 28 counties that Empire BlueCross BlueShield is licensed to operate in. You must be able to demonstrate upon request that you can meet at least 1 of the following 2 criteria. Please check the box next to the criteria you meet.

❒ Hold a valid New York motor vehicle operator's license or non-driver identification card with an address located in the Empire service area;

❒ Have evidence that you have a permanent dwelling place in the Empire service area (i.e, utility bill, certificate of residency);

8C. *Would you like Empire to choose your Primary Care Physician?
❒ YES ❒ NO If No, you must choose a PCP for each member listed, and indicate your choice in Section 8A.

8D. Do you have a child age 26 or over who is mentally retarded, physically handicapped or developmentally disabled for who coverage is being requested under this contract? ❒ YES ❒ NO
If yes, a separate enrollment form (HAC 506) must be submitted to determine eligibility. ❒ Please send me a form (HAC 506).

9. Are you, your spouse or dependent child a member of Empire BlueCross BlueShield or any Blue Cross Blue Shield Plan?
❒ YES ❒ NO If yes, please answer 9A-D and review 9E.

9A. Name and address of plan:

9B. Contract Holder's Name:

9C. Identification Number: Group Number

9D. Type of Coverage (check all that apply) ❒ Individual ❒ Family ❒ Group ❒ Non-Group ❒ Hospital ❒ Medical ❒ Dental

9E. If any family member listed on this contract is currently enrolled with Empire BlueCross BlueShield, that coverage will be cancelled if permitted under the terms of such other coverage. Membership will be transferred to the coverage requested, unless you indicated otherwise here and the reason is approved. ❒ **DO NOT TRANSFER REASON:**

_____

_____

10. You are submitting this application for:
❒ New Enrollment
❒ Conversion from prior Empire coverage
❒ Transfer from another Blue Cross Blue Shield Plan
❒ Contract Change
❒ Continuation of Former Dependent Coverage

11. Indicate your coverage choice (HMO or HMO/POS) and contract type (Individual, Family, Applicant/Spouse, Parent/Child(ren)).
Coverage Choice: ❒ HMO ❒ HMO/POS

Contract Type: ❒ Individual ❒ Family ❒ Applicant/Spouse ❒ Parent/Child(ren)

12. PLEASE ANSWER EACH OF THE FOLLOWING FOR YOU AND YOUR SPOUSE (IF ANY).

EMPLOYMENT STATUS	APPLICANT	SPOUSE
12A. SELF-EMPLOYED	❒ YES ❒ NO	❒ YES ❒ NO
12B. UNEMPLOYED	❒ YES ❒ NO	❒ YES ❒ NO
12C. CURRENTLY EMPLOYED*	❒ YES ❒ NO	❒ YES ❒ NO

IF YES, COMPLETE THE FOLLOWING

EMPLOYER'S NAME AND ADDRESS		
NUMBER OF EMPLOYEES (if known)		
DATE OF EMPLOYMENT		
FULL TIME		
PART TIME		

13. ARE YOU ELIGIBLE FOR COMPARABLE GROUP COVERAGE THROUGH AN EMPLOYER? ❒ **YES** ❒ **NO**
HAVE YOU BEEN REFUSED COMPARABLE COVERAGE THROUGH AN EMPLOYER? ❒ **YES** ❒ **NO**
IF THE ANSWER IS YES TO EITHER QUESTION, PLEASE SPECIFY REASON FOR SUBMISSION OF THIS APPLICATION:

_____

_____

IF YOU OR YOUR DEPENDENT(S) WERE COVERED BY ANOTHER INSURANCE CARRIER WITHIN SIXTY-THREE (63) DAYS OF THE EFFECTIVE DATE OF THIS CONTRACT YOU MAY BE ELIGIBLE FOR CREDIT TOWARD COMPLETION OF ANY APPLICABLE WAITING PERIOD FOR THE TIME ENROLLED WITH THAT CARRIER. TO DETERMINE ELIGIBILITY FOR THIS CREDIT, A LETTER OF PROOF FROM YOUR PRIOR CARRIER OR ANY REASONABLE SUBSTANTIATION OF PRIOR COVERAGE IS REQUESTED. THIS MUST CONTAIN NAME, CONTRACT TYPE, LEVEL OF BENEFITS AND PERIOD OF ENROLLMENT. NO PRE-EXISTING CONDITION EXCLUSION SHALL APPLY TO ANY "ELIGIBLE INDIVIDUAL," AS SUCH TERM IS DEFINED IN §2741(B) OF THE FEDERAL PUBLIC HEALTH SERVICE ACT. PRE-EXISTING CONDITION LIMITATIONS DO NOT APPLY TO APPLICANTS UNDER THE AGE OF NINETEEN (19).

14. IF YOU, YOUR SPOUSE OR YOUR DEPENDENT CHILD(REN) ARE CURRENTLY COVERED OR HAVE BEEN COVERED WITHIN THE PAST 63 DAYS UNDER ANY HEALTH BENEFITS PLAN, PLEASE PROVIDE THE INFORMATION REQUESTED BELOW:

14A. NAME AND ADDRESS OF PLAN	14B. NAME OF CONTRACT HOLDER
_____	14C. IDENTIFICATION NO.
_____	14D. REASON FOR TERMINATION
_____	

14E. Type of Policy (check all that apply) ❒ Individual ❒ Family ❒ Group ❒ Non-Group ❒ Hospital ❒ Medical ❒ Dental	14F. EFFECTIVE DATE MONTH / DAY / YEAR	14G. TERMINATION DATE MONTH / DAY / YEAR

15. Are you, your spouse or any of your dependent child(ren) covered by MEDICARE?
❒ YES ❒ NO If yes, taking information from the red, white and blue Medicare Card, enter the information requested below:

	APPLICANT	SPOUSE	CHILD (NAME _____)
Claim Number and letter			
Hospital Insurance Part A Effective Date			
Medical Insurance Part B Effective Date			

16. If applicant is married and is requesting Individual coverage, please check the appropriate box to indicate reason.

A. ❒ Spouse over age 65 years B. ❒ Spouse covered by Medicare (❒ over age 65 years ❒ under 65 years/disabled)

C. ❒ Spouse currently enrolled with Empire BlueCross BlueShield at place of employment and group coverage is not offered to spouse or children of employees.

Group Number_____ Spouse's Identification Number _____

D. ❒ Spouse currently enrolled with another health plan at place of employment and group coverage is offered to employees only. (A written statement from the group verifying this must be submitted with the application)

Name of Health Insurance Plan _____

E. ❒ Spouse permanently residing outside the United States (a notarized statement must accompany this application).

F. ❒ Spouse permanently confined to an institution.

Name of Institution _____

Address of Institution _____

Date of Confinement_____

READ THE FOLLOWING STATEMENT VERY CAREFULLY.

YOUR SIGNATURE(S) ON THIS PAGE INDICATE(S) THAT YOU HAVE READ, UNDERSTAND AND AGREE TO ALL THE PROVISIONS SET FORTH ON THIS APPLICATION AND THAT YOU UNDERSTAND AND AGREE TO THEM. PLEASE SIGN AND DATE.

A. I hereby request coverage of the type checked. If this request is for family members, the names of my spouse and eligible dependent children are listed. I make this application on their behalf as well as my own. If this request is accepted, coverage will be effective only if my payment of the subscription charge is received by Empire BlueCross BlueShield in accordance with the billing notice.

B. All statements and answers in this application are true and are representations made to induce the issuance of the contract applied for. The contract will become effective on the date specified on the identification card or the identification stub. On that date, my spouse's or my dependent's existing contracts with Empire BlueCross BlueShield, if any, shall be cancelled except as otherwise noted in item 9E. Any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact found in this application may result in rescission of this contract.

C. For applicants age nineteen (19) and older, there will be a 12-month waiting period for benefits for any physical or mental condition, regardless of the cause, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on your enrollment date for this coverage. Credit for prior creditable coverage will be applied to this waiting period if such coverage was continuous to a date not more than 63 days prior to your enrollment date for this coverage. In the case of previous HMO coverage, any affiliation period prior to that previous coverage becoming effective will also be credited. Upon request, you must provide appropriate documentation of the prior coverage to Empire BlueCross BlueShield.

D. I authorize any healthcare provider, payor of health and health-related claims, or government agency to furnish to Empire or its designee all records pertaining to medical history, services rendered and payments made regarding me or my dependents for review and evaluation of any claim or services in conjunction with managed care. I also authorize Empire to disclose such information to my PCP and other network physician(s), to another payor or self-insurer or to an Empire designee for purposes of continuity of care and medical management, disease management, managed disability coordination or financial audits. This authorization shall become effective immediately, and shall remain in effect for six years after the termination of the coverage, or the last determination or payment by Empire on a claim or service under the coverage, whichever is latest. This authorization shall be binding upon me, my dependents, my heirs, executors or administrators.

E. If this coverage is issued, I may make a written request to cancel the contract within 10 days after receipt. Thereafter, 30 days advance written notification to Empire BlueCross BlueShield by the contract holder is required to terminate coverage.

F. I understand that HMO benefits will be available only if I or my dependents receive covered services provided or authorized by the primary care physician. Otherwise:
– If this contract is HMO/POS coverage only out-of-plan benefits will be available.
– If this contract is HMO only coverage, no out-of-plan benefits will be available.

All statements and answers in this application are true, and are representations made to induce the issuance of coverage.
Any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact found in this application may result in cancellation or rescission of coverage. 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.

I understand and agree that by applying for the point of service program, I am applying to purchase both the Health Maintenance Organization (HMO) benefits contract as well as the companion rider for out-of-network benefits. By applying for the HMO program, I am applying to purchase the Health Maintenance Organization (HMO) benefits contract only.

I attest that I am a resident in one of the 28 counties that Empire BlueCross BlueShield is licensed to operate in and understand that I may be asked to provide evidence to demonstrate my residency per section 8.B.

I have read, understand and agree to all the provisions set forth.

Applicant's Signature _____ Date _____

Spouse's Signature _____ Date _____