Independent Health

Enrollment Application/Change Form

Please clearly **PRINT** all information

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

KEY

† *Supporting documentation required*

‡ *If allowed by plan; supporting documentation may be required*

§ *Must include date of qualifying event*

Employer Admin. Initials:	Date:

To avoid a delay in your health insurance coverage, please be sure ALL SECTIONS ARE COMPLETED

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

☐ Employer Group – actively employed ☐ COBRA ☐ Individual (application must include payment and supporting documentation)

A Coverage Information

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

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

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

☐ Other †_____

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

Check One:

☐ Terminate Employment ☐ Deceased ☐ Dependent Max age reached ☐ 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.*

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

C Employee/Individual Information

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Employee/Individual SSN

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

Employee Status if Applicable ☐ A (Active) ☐ R (Retired) ☐ C (Cobra)

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

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

( ) ( )

Gender **Mobile Phone No.** *(include area code)* **Home Phone No.** *(include area code)*

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

Primary Care Physician *(refer to Find A Doctor tool at independenthealth.com/findadoctor)*

Provider Name Provider Address Are you a current patient of this physician? *(Y or N)*

Other Health Insurance *Indicate if you or anyone else on this application will have other health insurance while enrolled with Independent Health. This is for informational purposes only, and the answers you provide will have no bearing on eligibility.*

Insurance Carrier Name Policy No./MBI Name of Insured

Are you or anyone included on this application covered by Medicare? ☐ Yes ☐ No 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 help secure this coverage through a plan underwritten and administered by Delta Dental of New York, Inc. Additional premium may apply.

Please complete the reverse of this application including dependent information (if applicable). Applicant signature required.

Employee/Individual Social Security Number ☐☐☐–☐☐–☐☐☐☐

Dependent #1

☐☐☐–☐☐–☐☐☐☐ † *Supporting documentation required* ‡ *If allowed by plan; supporting documentation required*

Dependent SSN

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 | **Mobile Phone No.** *(include area code)* | **Home Phone No.** *(include area code)*

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

Primary Care Physician *(refer to Find A Doctor tool at independenthealth.com/findadoctor)*

Provider Name | Provider Address | Are you a current patient of this physician? *(Y or N)*

Dependent #2

☐☐☐–☐☐–☐☐☐☐ † *Supporting documentation required* ‡ *If allowed by plan; supporting documentation required*

Dependent SSN

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 | **Mobile Phone No.** *(include area code)* | **Home Phone No.** *(include area code)*

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

Primary Care Physician *(refer to Find A Doctor tool at independenthealth.com/findadoctor)*

Provider Name | Provider Address | Are you a current patient of this physician? *(Y or N)*

Dependent #3

☐☐☐–☐☐–☐☐☐☐ † *Supporting documentation required* ‡ *If allowed by plan; supporting documentation required*

Dependent SSN

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 | **Mobile Phone No.** *(include area code)* | **Home Phone No.** *(include area code)*

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

Primary Care Physician *(refer to Find A Doctor tool at independenthealth.com/findadoctor)*

Provider Name | Provider Address | Are you a current patient of this physician? *(Y or N)*

For additional dependents, please attach an additional copy of this page. Applicant signature required.