Enrollment Application/Change Form



	EMPLOYER USE ONLY			
	Date Hired (MM/DD/YY) (required)	Full-	time Part-time (20 hours or less,	/week)
(Child)	Date coverage is effective		king OCOBRA	
		Retiree 65 or	older ○ Retiree 55–65 ○ Retire	ee Under 55
500 Patroon Creek Blvd.	Date of status change	Employer Name		
Albany, NY 12206-1057	Part- to full-time Union to non-ı	union Other		
(518) 641-3700 or	Group/Subgroup #:	Class	s #:	
1-800-777-2273	Chamber Assoc:	Grp	Admin Initials (required)	
A. EXPLANATION <i>(CHECK A</i>	LL THAT APPLY)			
New Hire Open Enrollment	○ Loss of Coverage ○ Marriage ○ Birth	Change in Student Sta	tus Opendent through 29	
Name/Address Change Cour	t Order			
COBRA—Reason: Left Employ	//Retirement Obivorce/Legal Separation	Death of Spouse D	ependent Reached Max Age Closs	of Student Status
Termination—Reason: ©Em	ployment Terminated Remove Depende	ents Only Oeceased	Other	
B. COVERAGE INFORMATIO	N (CHECK ALL THAT APPLY)			
roduct Type: OHMO OE	•	HNY		
CP Copay Amt: \$ Special	list Copay Amt: \$ % Coins:	Deduct. Amt: \$	ODelta Dental of N	ew York Coverage
C. FUNDING ACCOUNT (CH	ECK ALL THAT APPLY)			
am participating in a CDPHN-adm	· · · · · · · · · · · · · · · · · · ·			
Flexible Spending Account	(FSA) Health Reimbursement Arrangeme	ent (HRA)	vings Account (HSA) Onot Applica	ıble
	ndent MUST select a Primary Care Physician (
or HMOs only , you and each deper atient and get the Physician # and you have Medicare Parts A and B	*		all other products, include copy of yo	
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*You are not required to answer. This information is important, however, as it helps us understand the diversity of our membership.

For HMOs only , you and each depender patient and get the Physician # and Offi If you have Medicare Parts A and B, inc	ce Location fro	m the provider directo					
8a. Last	First		M.I.	SSN (Required,) 	Date of Birth	Medical Add <i>or</i> Delete
Rel: <i>Spouse Other</i> Se	x:	Disabled	\bigcirc I	End-Stage Renal Di	isease		\circ \circ
Medicare number:	Pa	art A effective date:		F	Part B effective	e date:	— Delta Dental
For enrollees in small group (100 or fev pediatric dental essential health benef New York Health Benefit Exchange?	it through a Ne						Add or Delete
If you answered "yes," please provide							_
If you answered "no," we will provide yo		•					for rate information.
Primary Language (optional*): Spoken:							_
Ethnicity (optional*):	_		_		_	-	
Previous coverage:	arrier:			_ Effective from:		To:	
HMO only—Physician (PCP) Last		First			Phys #		Current Patient?
OB/GYN Last		First			Phys #		Current Patient?
							_
8b. Last	First		M.I.	SSN (Required))	Date of Birth	Medical Add <i>or</i> Delete
Rel: <i>Son Daughter</i>	← Full-time	e student?	\bigcirc	Disabled (End-Stage	Renal Disease	0 0
Medicare number:	Pa	art A effective date:			_	e date:	Delta Dental
For enrollees in small group (100 or fee pediatric dental essential health benef New York Health Benefit Exchange? If you answered "yes," please provide	it through a Ne Yes the name of th	ew York Health Benefit) No e company issuing the	Exchang e stand-a	ge-certified stand	-alone dental rage	plan offered outside the	Add or Delete
If you answered "no," we will provide yo		•					for rate information.
Primary Language (optional*): Spoken:							_
Ethnicity (optional*): White Bravious assures	_		_		_		
Previous coverage: Yes Previous C	arrier:	First		_ Effective from:		To:	Current Patient?
HMO only—Physician (PCP) Last		FIISt			Phys#		Current Patient:
OB/GYN Last		First			Phys #		Current Patient?
8c. Last	First		M.I.	SSN (Required)		Date of Birth	Medical
							Add <i>or</i> Delete
Rel: <i>Son Daughter</i>	○ Full-time		_		○ End-Stage	Renal Disease	\circ
Medicare number:	Pa	art A effective date:		F	Part B effective	e date:	 Delta Dental
For enrollees in small group (100 or few pediatric dental essential health benefit New York Health Benefit Exchange?	it through a Ne						Add <i>or</i> Delete
If you answered "yes," please provide	the name of th	e company issuing the	e stand-a	ılone dental cover	rage		
If you answered "no," we will provide yo					_		for rate information.
Primary Language (optional*): Spoken:		-					_
Ethnicity (optional*): White B							
Previous coverage: Yes Previous C	arrier:			_ Effective from:		To:	_
HMO only—Physician (PCP) Last		First			Phys#		Current Patient?
OB/GYN Last		First			Phys #		Current Patient?

E. DEPENDENT INFO

Note: Make sure you sign and date the application on the next page.

E. DEPENDENT INFO Cont'd					
8d. Last	First	M.I. SSN (Required		Date of Birth	Medical Add <i>or</i> Delete
Rel: <i>Son Daughter</i>	○ Full-time student?	\bigcirc D	isabled	End-Stage Renal Disease	0 0
Medicare number:	Part A effective date:		Pa	art B effective date:	— Delta Dental
	efit through a New York Health Ber			lone dental coverage that provides a alone dental plan offered outside the	Add or Delete
If you answered "yes," please provid	e the name of the company issuing	g the stand-al	one dental covera	age	
If you answered "no," we will provide	you coverage of the pediatric dental	essential hea	alth benefit. Additi	onal cost may apply. Ask your employe	for rate information
Primary Language (optional*): Spoke	n:		Written:		_
Ethnicity (optional*):	Black American Indian/Alaska	Native O	Asian/Pacific Islan	der OHispanic/Latino Other	
Previous coverage:	carrier:		Effective from:	To:	_
HMO only—Physician (PCP) Last	First			Phys #	Current Patient?
OB/GYN Last	First			Phys #	Current Patient?
F. OTHER INSURANCE					
Do you, your spouse, or any of your depe	ndents have any other medical insura	nce that will be	e maintained in add	lition to CDPHP? \bigcirc Yes: <i>If yes, complete</i>	te below. ONo
9. Policyholder name	Policy #	I	Insurance carrier	Employer name	
Date of birth:	Address:				
Effective date:	Coverage type:	○ Hospital	○Medical	Orug Opental Ovision	
Covered Individuals—Check all that app	ly Self Spouse O	Dependents			
	I hereby represent that all inf read the important informati			e hereon is true and complete to s s form.	the best of my
any materially false information, or c	onceals for the purpose of misleadi	ing, informati	on concerning an	application for insurance or statemen y fact material thereto, commits a frauce of the claim for each such violation.	
10. Applicant's Signature:				11. Date:	

IMPORTANT INFORMATION

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® member services department at (518) 641-3700 or 1-800-777-2273. Thank you for choosing CDPHP for your health care coverage.

Your signature on this application hereby affirms the following:

On behalf of myself and any dependents listed, I hereby apply for coverage under the Master Group Contract (health and/or dental, as the case may be) issued to my employer by Capital District Physicians' Health Plan, Inc. (HMO products) and/or CDPHP Universal Benefits, Inc. (CDPHP UBI) (EPO/PPO/HD products) and/or Delta Dental of New York, Inc.

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 further understand that for HMO benefits provided by Capital District Physicians' Health Plan, Inc., except for emergencies, covered services must be obtained through a participating physician (unless otherwise noted in rider) or in a participating hospital (unless otherwise noted in rider) when admitted or referred by a participating physician (unless otherwise noted in rider), and also that certain services may require a copayment (unless otherwise noted in rider) by me (or my dependents) directly to the provider of such services.

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 and/or Delta Dental of New York, Inc., 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.

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

CDPHP COMPANIES

Capital District Physicians' Health Plan, Inc. CDPHP Universal Benefits. Inc.

Delta Dental Service Plans are underwritten and administered by Delta Dental of New York, Inc.



Delta Dental of New York One Delta Drive Mechanicsburg, PA 17055 1-800-932-0783 TTY/TDD 1-888-373-3582 www.deltadentalins.com

A REGISTERED MARK OF DELTA DENTAL PLANS ASSOCIATION

*You are not required to answer. This information is important, however, as it helps us understand the diversity of our membership.

Form # 02-0010-2016

Page 3 of 3