

INSTRUCTIONS

Please take the time to carefully complete all sections of this application which 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.

PROOF OF RESIDENCY (i.e., copy of voter registration card, driver's license, car registration, utility bill, certificate of residency) must be sent with the application. 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, Bronx, Clinton, 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.

Current proof of residency must match home address on application. PO Boxes are not accepted.

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

Section 10: Please check the applicable box.

Section 11: Your choice of contract must be appropriate.

TYPE OF COVERAGE:

- The TraditionPLUS Hospital contract is available to persons applying for new enrollment, conversion, contract change or continuation of dependent coverage.

To be Classified as a Family:

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

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.

DEPENDENT CHILDREN:

- A child is considered a dependent if he or she is under 23, unmarried and dependent upon you for support. A child is considered under age 23 until December 31st of the year he or she becomes age 23. Proposed adoptive children and over age 23 disabled dependent children also qualify.

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, along with proof of residency. If you have any questions about this program or need assistance in completing this application, please call our Dedicated Service Area at (800) 261-5962. We will be glad to help you.

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	
3. HOME ADDRESS					
CITY		STATE	ZIP CODE	CARE OF	
4. MALE <input type="checkbox"/>	FEMALE <input type="checkbox"/>	5. DATE OF BIRTH	6. SINGLE <input type="checkbox"/>	MARRIED <input type="checkbox"/>	SEPARATED <input type="checkbox"/>
			DIVORCED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	7. DATE OF MARRIAGE
8A. Please tell us about your spouse and dependent children. If you are applying for family coverage, 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 NUMBER
SPOUSE			<input type="checkbox"/> M <input type="checkbox"/> F		
CHILD			<input type="checkbox"/> M <input type="checkbox"/> F		
CHILD			<input type="checkbox"/> M <input type="checkbox"/> F		
CHILD			<input type="checkbox"/> M <input type="checkbox"/> F		
CHILD			<input type="checkbox"/> M <input type="checkbox"/> F		
8B. Do you have a child over age 23 who is mentally retarded, physically handicapped or developmentally disabled for whom coverage is being requested under this family contract? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, a separate enrollment form (HAC 506) must be submitted to determine eligibility. <input type="checkbox"/> Please send me a form (HAC 506).					
9. Are you, your spouse or dependent child a member of Empire BlueCross BlueShield or any BlueCross Blue Shield Plan? <input type="checkbox"/> YES <input type="checkbox"/> 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) <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Group <input type="checkbox"/> Non-Group <input type="checkbox"/> Hospital <input type="checkbox"/> Medical <input type="checkbox"/> 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. <input type="checkbox"/> DO NOT TRANSFER REASON: _____ _____ _____					
10. You are submitting this application for: <input type="checkbox"/> New Enrollment <input type="checkbox"/> Conversion from prior Empire coverage			<input type="checkbox"/> Transfer from another Blue Cross Plan <input type="checkbox"/> Contract Change <input type="checkbox"/> Continuation of Former Dependent Coverage		
11. Indicate your choice and contract type (Individual or Family). HOSPITAL PROGRAM 365 Day Hospital Coverage Contract Type: <input type="checkbox"/> Individual <input type="checkbox"/> Family					
12. If we accept this application, who will pay the premium? <input type="checkbox"/> Self <input type="checkbox"/> Employer <input type="checkbox"/> Other _____					

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

EMPLOYMENT STATUS	APPLICANT	SPOUSE
12A. SELF-EMPLOYED	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
12B. UNEMPLOYED	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
12C. CURRENTLY EMPLOYED*	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

*IF YES, COMPLETE THE FOLLOWING

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

14. 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 (60) 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.

15. 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:

15A. NAME AND ADDRESS OF PLAN _____ _____ _____	15B. NAME OF CONTRACT HOLDER
	15C. IDENTIFICATION NO.
	15D. REASON FOR TERMINATION
15E. Type of Policy (check all that apply) <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Group <input type="checkbox"/> Non-Group <input type="checkbox"/> Hospital <input type="checkbox"/> Medical <input type="checkbox"/> Dental	15F. EFFECTIVE DATE MONTH DAY YEAR
	15G. TERMINATION DATE MONTH DAY YEAR

16. 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			

17. 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 a family contract, 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. If accepted, this application will be part of the contract. 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 misrepresentation by me of facts which are material to this application may result in rescission of this contract.
- C. There will be an eleven 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 our 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 health care provider, payer 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 authorize Empire to disclose such information to my physician; another payer or self-insurer, and if my coverage is under a group contract held by an employer, association, trust fund, or similar entity, to the group contract holder, 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 coverage, or the last determination or payment by Empire on a claim or service under the coverage. 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.

All statements and answers in this application are true, and are representations made to induce the insurance of coverage. Any misrepresentation of material fact 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 have read, understand and agree to all the provisions set forth.

Applicant's Signature _____ Date _____

Spouse's Signature _____ Date _____

BE SURE TO INCLUDE ACCEPTABLE PROOF OF RESIDENCE. IF NEEDED, REFER TO PAGE 1 FOR INFORMATION.