Off Exchange

Add/Change/Termination Form
GROUP ADMINISTRATION

HEALTH REPUBLIC
INSURANCE OF NEW YORK

A. GENERAL INFORMATION

Group ID Number _____ Group Name _____ Date ____-____-____

B. TRANSACTION

	EFFECTIVE DATE	REQUIRED INFORMATION
❑ **Addition*** Complete WHO, REASON and SECTION C * Provide documentation as required	____-____-____	**WHO** ❑ Spouse/Partner ❑ Dependent(s) ❑ NY Young Adult **REASON** ❑ Open Enrollment ❑ Loss of Coverage ❑ Birth/Adoption ❑ Marriage ❑ Civil Union ❑ Partnership ❑ Other _____
❑ **Information Change/Correction** ❑ Name ❑ Date of Birth ❑ SSN ❑ Address ❑ Email ❑ Phone ❑ Gender	____-____-____	Last Name _____ First Name _____ M.I._____ Date of Birth ____-____-____ SSN _____ Address _____ City _____ State_____ Zip_____ Email_____ Phone _____ Gender ❑ Female ❑ Male
❑ **Termination**	____-____-____	**WHO** ❑ Employee ❑ Spouse/Partner ❑ Dependent(s) ❑ NY Young Adult Member ID #_____Member Name_____ **REASON** ❑ Left Employer ❑ Discontinuation of COBRA ❑ Switched Plans ❑ Discontinuation of NY Young Adult ❑ Other _____
❑ **Change Plan** Complete entire section	____-____-____	New Plan _____ Reason _____
❑ **COBRA or State Continuation**	____-____-____	**WHO** ❑ Employee ❑ Spouse/Partner* ❑ Dependents(s)* **REASON** ❑ Left Employer ❑ Hours Reduction ❑ Other_____ Date of Event ____-____-____ *A New Member Enrollment Form is required for Loss of Dependent Status, Divorces/Separation or Death of Subscriber

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C. DEPENDENT INFORMATION

	SPOUSE/DOMESTIC PARTNER/CIVIL UNION		NEW DEPENDENT		NEW DEPENDENT	
Social Security Number	_____		_____		_____	
Last Name	_____		_____		_____	
First Name, Middle Intial	_____		_____		_____	
Date of Birth (mm/dd/yy)	____-____-____		____-____-____		____-____-____	
Gender and Disability Status	❑ F ❑ M	❑ Disabled	❑ F ❑ M	❑ Disabled	❑ F ❑ M	❑ Disabled
Check "Yes" or "No"	Actively Employed ❑ Y ❑ N		N/A		N/A	

D. COORDINATION OF BENEFITS

		SPOUSE	DEPENDENT	DEPENDENT
Medicare	Check appropriate box and list effective date	❑ Part A ____-____-____ ❑ Part B ____-____-____ ❑ Part D ____-____-____	❑ Part A ____-____-____ ❑ Part B ____-____-____ ❑ Part D ____-____-____	❑ Part A ____-____-____ ❑ Part B ____-____-____ ❑ Part D ____-____-____
Medical ❑ Same for all	Policy Number	_____	_____	_____
	Carrier	_____	_____	_____
	Policy Holder	_____	_____	_____
	Effective Date	____-____-____	____-____-____	____-____-____

All transactions are effective on the first day of the next month

The completed form must be signed and any required documentation sent to Health Republic Insurance of New York via one of the following methods:

Mail to:
Health Republic Insurance of New York
Attn: Pre-Enrollment
30 Broad St., 7th Floor
New York, NY 10004

Brokers – please email:
brokers@newyork.healthrepublic.us

Members or Group Administrators – please fax:
1-855-201-7829

If you have any questions please call our member services team at **888-990-5702.**

Group Administration Signature_____ Date ____-____-____

Member Signature_____ Date ____-____-____