Enrollment Form
SMALL GROUP SUBSCRIBER

HEALTH REPUBLIC
INSURANCE OF NEW YORK

1. GROUP INFORMATION

Group Name _____ Group Number (if available) _____

2. SUBSCRIBER INFORMATION

Last Name _____ First Name: _____ M.I. ____ Gender ❑ Female ❑ Male

Date of Birth (mm/dd/yy) _____ Social Security Number _____

Home Phone _____ Daytime Phone _____

Relationship Status: ❑ Single ❑ Married ❑ Domestic Partner E-Mail _____

Are you enrolled in Medicare? ❑ Yes ❑ No If **"Yes",** Effective Date ____/____/____ ❑ Part A ❑ Part B ❑ Part D

Street Address _____ Apt. _____

City _____ State _____ Zip _____

County _____

3. INSURANCE INFORMATION

SELECT A PLAN:

EssentialCare

- ❑ EssentialCare Bronze Plan
- ❑ EssentialCare Silver Plan
- ❑ EssentialCare Gold Plan
- ❑ EssentialCare Platinum Plan
- ❑ EssentialCare Bronze Plan 29
- ❑ EssentialCare Silver Plan 29
- ❑ EssentialCare Gold Plan 29
- ❑ EssentialCare Platinum Plan 29

TotalFreedom

- ❑ TotalFreedom Platinum Plan
- ❑ TotalFreedom Platinum Plan 29

PrimarySelect

- ❑ PrimarySelect Silver Plan
- ❑ PrimarySelect Gold Plan
- ❑ PrimarySelect Platinum Plan
- ❑ PrimarySelect Silver Plan 29
- ❑ PrimarySelect Gold Plan 29
- ❑ PrimarySelect Platinum Plan 29

PrimarySelect PCMH

- ❑ PrimarySelect PCMH Silver Plan
- ❑ PrimarySelect PCMH Silver Plan 29

Effective Date

/ 01 / **(mm/01/yy)**

MUST BE 1ST OF MONTH

Date of Hire

/ / **(mm/dd/yy)**

Are you enrolling in COBRA?

❑ Yes ❑ No

Will you be covered by any other health insurance (including Medicare) in addition to the coverage you are electing now? ❑ **Yes** ❑ **No**

If **Yes**: Carrier Name _____ Policy Number _____ Effective Date _____ *(mm/dd/yy)*

Carrier Address _____

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",** please be aware that such coverage is required in New York State. Through an arrangement with Health Republic Insurance of New York, Solstice Health Insurance Company will provide you this coverage, and bill you separately. Please visit healthrepublic.mysolstice.net. If you have any questions, please call us at 888-990-5702.

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4. DEPENDENT INFORMATION

SPOUSE/DOMESTIC PARTNER:

Last Name _____ First Name _____ M.I. ____ Gender ❑ Female ❑ Male

Date of Birth *(mm/dd/yy)*_____ Social Security Number _____ Relationship ❒ Spouse ❒ Domestic Partner

Is this dependent enrolled in Medicare? ❑ Yes ❑ No If "Yes", Effective Date ____/____/____ ❑ Part A ❑ Part B ❑ Part D

Email_____ Home Phone _____

DEPENDENT 1:

Last Name _____ First Name _____ M.I. ____ Gender ❑ Female ❑ Male

Date of Birth *(mm/dd/yy)*_____ Social Security Number _____

Is this dependent enrolled in Medicare? ❑ Yes ❑ No If "Yes", Effective Date ____/____/____ ❑ Part A ❑ Part B ❑ Part D

Email_____ Home Phone _____

DEPENDENT 2:

Last Name _____ First Name _____ M.I. ____ Gender ❑ Female ❑ Male

Date of Birth *(mm/dd/yy)*_____ Social Security Number _____

Is this dependent enrolled in Medicare? ❑ Yes ❑ No If "Yes", Effective Date ____/____/____ ❑ Part A ❑ Part B ❑ Part D

Email_____ Home Phone _____

DEPENDENT 3:

Last Name _____ First Name _____ M.I. ____ Gender ❑ Female ❑ Male

Date of Birth *(mm/dd/yy)*_____ Social Security Number _____

Is this dependent enrolled in Medicare? ❑ Yes ❑ No If "Yes", Effective Date ____/____/____ ❑ Part A ❑ Part B ❑ Part D

Email_____ Home Phone _____

DEPENDENT 4:

Last Name _____ First Name _____ M.I. ____ Gender ❑ Female ❑ Male

Date of Birth *(mm/dd/yy)*_____ Social Security Number _____

Is this dependent enrolled in Medicare? ❑ Yes ❑ No If "Yes", Effective Date ____/____/____ ❑ Part A ❑ Part B ❑ Part D

Email_____ Home Phone _____

If you have additional dependents, please provide their information on a separate sheet of paper.

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5. ACKNOWLEDGEMENT *(Read Carefully Before Signing)*

I, the Primary Proposed Insured (or Spouse signing below), by my signature set forth thereafter agree to the following: (a) All statements and answers in this enrollment form are complete and true to the best of my knowledge and belief. (b) Insurance will take effect only if a certificate is issued and the first premium is paid in full. (c) No agent has the authority to waive any answer or otherwise modify this application or to bind the Company in any way by making any promise or representation which is not set out in writing in this application.

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.

Member Signature Date

Print Name

Authorized Group Benefits Administrator Date

Print Name

Preferred method of Communication

❒ Mail ❒ Email