PLEASE USE BLACK INK ONLY. *For address changes and/or primary care physician changes simply call (518) 641-3700 or 1-800-777-2273 or visit www.cdphp.com. There is no need to complete this form.*

500 Patroon Creek Blvd.
Albany, NY 12206-1057
(518) 641-5000 or 1-800-993-7299

Enrollment Application/ Change Form

EXPLANATION

Check all that apply	Explanation and Effective Date
☐ New Enrollment ☐ Name Change ☐ Cobra Continuation ☐ Add Dependent	☐ New Hire ☐ Open Enrollment ☐ Qualifying Event/Reason: ______ ☐ Loss of Coverage *(include proof—HIPAA Cert.)* ☐ **Effective Date** ______
☐ Termination ☐ Remove Dependent Only	☐ Employee Terminated ☐ Moved Out of Area ☐ Open Enrollment—Transferred to another plan ☐ Dissatisfaction ☐ Cost ☐ Spouse's Coverage ☐ Other: ______ **Effective Date:** ______

EMPLOYER USE

Date hired ___ /___ /___ Date of status change ___ /___ /___
☐ Part- to full-time ☐ Temporary to permanent
☐ Union to non-union ☐ Other ______
Date coverage is to be effective: ______
Group/Division # : ___ ___ ___ ___ ___ ___ ___ - ___ ___ ___ ___
Employee Status: A. ☐ Full-time ☐ Part-time *(hours per week)* ______
B. ☐ Active ☐ Retiree ☐ Salaried ☐ Union ☐ Other
Group Administrator Initials *(required)* ______

Check Type of Coverage: ■ HMO ■ POS

SUBSCRIBER

1. First Name M.I. Last Name
2. Street Address Apt. #
3. City State County Zip Code
4. Your Social Security # ___ ___ ___ – ___ ___ – ___ ___ ___ ___
5. Telephone:
Home: ( ) –
Work: ( ) –
6a. Employer Name
6b. Chamber/Association
7. Primary language if other than English:

8. MEMBER INFORMATION

Add	Delete	Name: Indicate different last names, if applicable. List oldest dependents first. First M.I. Last	Date of Birth (mm/dd/yy)	Relationship	Social Security Number	Medicare A & B* Effective Date **Copy of Medicare Card must be attached.*	Full-Time Student	You, and each dependent, **must** select a **Primary Care Physician (PCP)**. Females may also choose one OB/GYN. For all selections, indicate if you are a current patient and the Physician # and office location from the provider directory. **Physician First and Last Name**	**Office Location**	Physician Number	✔ if current patient
☐	☐	00 Applicant	/ /	Self ☐ M ☐ F		☐ A / / ☐ B / /		PCP OB/GYN			☐ ☐
☐	☐	01	/ /	☐ Husband ☐ Wife ☐ Other		☐ A / / ☐ B / /		PCP OB/GYN			☐ ☐
☐	☐	02	/ /	☐ Son ☐ Daughter		☐ A / / ☐ B / /	☐ Yes ☐ No	PCP OB/GYN			☐ ☐
☐	☐	03	/ /	☐ Son ☐ Daughter		☐ A / / ☐ B / /	☐ Yes ☐ No	PCP OB/GYN			☐ ☐
☐	☐	04	/ /	☐ Son ☐ Daughter		☐ A / / ☐ B / /	☐ Yes ☐ No	PCP OB/GYN			☐ ☐

9. DEPENDENT

Full-time college students age 19 and over: Expected Date of Graduation:
School Name and Address:

Do you have a disabled dependent beyond age 19?
☐ No ☐ Yes (list name[s]):

10. OTHER INSURANCE

Other Coverage—Do you, your spouse, or any of your dependents have any other medical insurance that will be maintained in addition to CDPHP? ☐ **Yes** *If yes, complete below.* ☐ **No**

Policyholder name:
Relationship: ☐ Self ☐ Spouse ☐ Child
Social Security Number:
Date of Birth: / /
Insurance Carrier:
Policy #:
Effective Date:
Address:
Employer Name:
Telephone:
Covered Individuals:
Plan Type: ☐ Self Only ☐ Self & Family
Coverage Type: ☐ Hospital ☐ Medical ☐ Drug ☐ Dental ☐ Vision

11. SIGNATURE

AGREEMENT: I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge and that I have read the important information on the reverse side of this form.

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 $5,000 and the stated value of the claim for each such violation.

Applicant's Signature Date

CDPHP Companies: Capital District Physicians' Health Plan, Inc. (CDPHP); CDPHP Universal Benefits, Inc. (CDPHP UBI)

Form 5315-0108

ORIGINAL to be forwarded to CDPHP • SECOND PAGE to be retained by EMPLOYER • LAST PAGE to be retained by EMPLOYEE to serve as a temporary ID card (subject to eligibility).

IMPORTANT

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 Marketing Department at (518) 641-5000 or 1-800-993-7299. Thank you for choosing CDPHP for your health care coverage.

Your signature on the reverse of this application hereby affirms the following:

On behalf of myself and any dependents listed, I hereby apply for coverage under the Master Group Contract issued to my employer by Capital District Physicians' Health Plan, Inc. and/or CDPHP Universal Benefits, 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 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.