



# TRANSACTION FORM FOR GROUP ACCOUNTS

MEMBERSHIP / P.O. BOX 2820 • NEW YORK, NY 10116-2820

(Please read important information on back before completing this form)

INTERNAL USE ONLY  
CONTROL NUMBER

I. SUBSCRIBER INFORMATION										
LAST NAME		FIRST NAME			M.I.	TELEPHONE NUMBERS <b>HOME</b>		<b>WORK</b>		<b>FAX</b>
HOME ADDRESS (Include Apartment Number)					<b>SEX</b> <input type="checkbox"/> Male <input type="checkbox"/> Female		<b>MARITAL STATUS</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other _____			
CITY	STATE		ZIP CODE		<b>EMPLOYMENT STATUS</b> <input type="checkbox"/> Employed <input type="checkbox"/> Not-Employed <input type="checkbox"/> Retired <input type="checkbox"/> COBRA			<b>PRIMARY LANGUAGE SPOKEN</b>		

II. ENROLLMENT INFORMATION													
NAME			DATE OF BIRTH	SOCIAL SECURITY	SEX	RELATION-	MAILING ADDRESS	EMAIL ADDRESS		FULL TIME	ADD	DELETE	RACE/ETHNICITY
LAST	FIRST	M.I.	MO/DAY/YR	NUMBER		SHIP	(If different from above)			STUDENT (√)	(√)	(√)	(CODES BELOW)
SUBSCRIBER						SELF							
SPOUSE													
DEPENDENT													
DEPENDENT													
DEPENDENT													

III. OTHER CARRIER INFORMATION										
Do you or any of your dependents have other health care coverage? <input type="checkbox"/> Yes Please complete this section <input type="checkbox"/> No GO TO SECTION IV										
NAME OF OTHER INSURANCE CARRIER			TYPE OF CONTRACT <input type="checkbox"/> Group <input type="checkbox"/> Individual		NAME OF POLICY HOLDER		LAST NAME		FIRST NAME	M.I.
CARRIER'S ADDRESS			CITY	STATE	ZIP CODE	POLICY NUMBER		EFFECTIVE DATE		

IV. DID YOU HAVE PRIOR HEALTH COVERAGE <input type="checkbox"/> YES Please provide a 12-month history of all coverage in this section <input type="checkbox"/> NO GO TO SECTION VI						
	NAME AND ADDRESS OF INSURER	TELEPHONE NUMBER OF INSURER	NAME OF POLICYHOLDER	POLICY I.D. NUMBER	EFFECTIVE DATE OF CURRENT OR PRIOR POLICY	TERMINATION DATE OF CURRENT OR PRIOR POLICY
HOSPITAL						
MEDICAL						

V. EMPLOYER INFORMATION			
GHI CERTIFICATE NUMBER OR EMPLOYEE SOCIAL SECURITY NUMBER		DATE OF HIRE	EMPLOYEE WAITING PERIOD <input type="checkbox"/> YES NUMBER OF WAITING PERIOD DAYS _____ <input type="checkbox"/> NOT APPLICABLE NUMBER OF ACTIVE EMPLOYEES IN YOUR GROUP _____
<b>Check one:</b> <input type="checkbox"/> New Enrollment <input type="checkbox"/> Reinstatement <input type="checkbox"/> Termination			
<b>STATUS CHANGE:</b> <input type="checkbox"/> Add Dependent <input type="checkbox"/> Remove Dependent <input type="checkbox"/> Address Change <input type="checkbox"/> Name Change Reason for Change: _____			
<b>TRANSFER:</b> <input type="checkbox"/> To Another Carrier <input type="checkbox"/> GHI Group # Change: From _____ To _____ Is applicant currently working at least 20 hours per week? <input type="checkbox"/> Yes <input type="checkbox"/> No			

VI. SUBSCRIBER AUTHORIZATION		GROUP AUTHORIZATION	
Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim concerning 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, shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.			
Subscriber Signature _____		Authorized Signature _____	
Date _____		Date _____ Phone Number _____	

VII. GROUP NAME AND ADDRESS			EFFECTIVE DATE OF TRANSACTION	GHI GROUP NUMBER
			MEDICAL	MEDICAL
			HOSPITAL	HOSPITAL
			DENTAL	DENTAL

**RACE/ETHNICITY CODES:** (Optional) A = ASIAN B = BLACK OR AFRICAN AMERICAN C = CAUCASIAN H = HISPANIC OR LATINO  
 I = NATIVE AMERICAN OR ALASKAN NATIVE P = NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER O = OTHER **SEE INFORMATION/EXPLANATION ON REVERSE SIDE**

## IMPORTANT INFORMATION

- 1- The subscriber must complete sections I through IV. The group plan administrator must complete section V. Both the subscriber and the administrator must complete section VI.
- 2- All effective dates of transactions may not exceed thirty (30) days retroactive from the next billing date.
- 3- For group accounts with student dependent coverage: A full-time dependent student is a person who meets all of the following conditions:  
He/she is at least 19 years of age, unmarried, receives at least half of his/her support from the employee or member, and is enrolled full-time in an accredited educational institution. The institution must grant a degree or diploma. The student must be listed as a dependent when you enroll for coverage.  
To enroll the dependent as a full-time student, attach a complete Student Dependent Certification Form or attach a copy of the most recent Bursar's receipt. See your group plan administrator for a Dependent Student Certification Form.
- 4- Failure to complete any part of this form (e.g., group number, reason for submission, certificate number, etc.) will delay the processing of the transaction.
- 5- Failure to have the proper signatures and authorization will require GHI to return this transaction form to the employer group administrator.

### Why We Ask You for Race/Ethnicity Information

National studies show that differences in access to health care occur along ethnic lines. In our effort to ensure that everyone we serve receives appropriate care, GHI, along with other health insurers, is collecting data on ethnicity with the goal of improving access to care and outcomes for groups who often have poorer results. Information will only be used by our Medical Department to improve access to needed care and will not be available to any other staff. Answering this question is voluntary.

### GHI Web Site

For fast, convenient access to the latest claim status, eligibility, and benefits information, visit GHI's secure Web site at [www.ghi.com](http://www.ghi.com). Available around the clock, on the site you can also find provider listings, order ID cards, view an online Explanation of Benefits, access wellness information, and much more.

### Translation Services

If English is not your primary language and translation services are needed when calling GHI Customer Service, a representative can help you.