Enrollment Application/Change Form



	EMPLOYER USE ONLY			
	Date Hired (MM/DD/YY) (required)	Full-t	me Part-time (20 hours or less,	/week)
	Date coverage is effective	OActively Work	ing COBRA	
		Retiree 65 or o	lder Retiree 55–65 Retire	ee Under 55
500 Patroon Creek Blvd.	Date of status change	Employer Name		
Albany, NY 12206-1057	Part- to full-time Union to non-u	nion Other		
(518) 641-3700 or	Group/Subgroup #:	Class	#:	
1-800-777-2273	Chamber Assoc:	Grp <i>A</i>	dmin Initials (required)	
A. EXPLANATION <i>(CHECK A</i>	LL THAT APPLY)			
	○ Loss of Coverage ○ Marriage ○ Birth	Change in Student Statu	s Opendent through 29	
Name/Address Change Cour	t Order			
COBRA—Reason: Left Employ	y/Retirement ODivorce/Legal Separation (Death of Spouse OPe	pendent Reached Max Age OLoss	of Student Status
Termination—Reason:	ployment Terminated Remove Depende	ents Only Oeceased	Other	
B COVERAGE INFORMATIO	N (CHECK ALL THAT APPLY)			_
roduct Type: OHMO OE		HNY		
CP Copay Amt: \$ Specia	list Copay Amt: \$ % Coins:	Deduct. Amt: \$	OPelta Dental of N	ew York Coverage
C. FUNDING ACCOUNT <i>(CH</i>				
am participating in a CDPHN-adm	·			
Flexible Spending Account		ent (HRA) Health Savi	ngs Account (HSA) Not Applica	ible
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*You are not required to answer. This information is important, however, as it helps us understand the diversity of our membership.

For HMOs only , you and each dependent patient and get the Physician # and Office If you have Medicare Parts A and B, incl	e Location from the	provider director					
8a. Last	First		M.I.	SSN (Required	D 	Date of Birth	Medical Add <i>or</i> Delete
Rel: <i>Spouse Other</i> Sex	:	Oisabled	\bigcirc I	End-Stage Renal D	isease		\circ \circ
Medicare number:	Part A e	ffective date:			Part B effectiv	ve date:	- Delta Dental
For enrollees in small group (100 or few pediatric dental essential health benefi New York Health Benefit Exchange?							Add or Delete
If you answered "yes," please provide t							_
If you answered "no," we will provide you							for rate information.
Primary Language (optional*): Spoken:							-
Ethnicity (optional*):	_		_		_	-	
Previous coverage: Yes Previous ca	ırrier:			_ Effective from:		To:	
HMO only—Physician (PCP) Last		First			Phys #		Current Patient?
OB/GYN Last		First			Phys#		Current Patient?
8b. Last	First		M.I.	SSN (Required	0	Date of Birth	Medical Add <i>or</i> Delete
Rel: <i>Son Daughter</i>	○ Full-time stud	ent?	\bigcirc I	Disabled	○ End-Stage	Renal Disease	\circ
Medicare number:	Part A e	ffective date:			Part B effectiv	e date:	- Delta Dental
For enrollees in small group (100 or few pediatric dental essential health benefi New York Health Benefit Exchange? If you answered "yes," please provide t	through a New Yo	rk Health Benefit	Exchang	ge-certified stand	l-alone denta	l plan offered outside the	Add or Delete
If you answered "no," we will provide you	coverage of the pe	diatric dental esse	ential he	alth benefit. Addi	tional cost m	ay apply. Ask your employer	for rate information.
Primary Language (optional*): Spoken:				Written:			_
Ethnicity (optional*): White Bl. Previous coverage: Yes Previous co	_		_		_	spanic/Latino Other To:	_
HMO only—Physician (PCP) Last		First			Phys#		Current Patient?
OB/GYN Last		First			Phys #		Current Patient?
8c. Last	First		M.I.	SSN (Required	0	Date of Birth	Medical
Rel: <i>Son Daughter</i>	Full-time stude	ont?		Disabled	Cend Stage	Renal Disease	Add <i>or</i> Delete
Medicare number:	_	ffective date:	_			ve date:	0 0
For enrollees in small group (100 or few							 Delta Dental Add or Delete
pediatric dental essential health benefi							
If you answered "yes," please provide t	ne name of the com	pany issuing the	stand-a	lone dental cove	rage		_
If you answered "no," we will provide you	coverage of the pe	diatric dental esse	ential he	alth benefit. Addi	itional cost m	ay apply. Ask your employer	for rate information.
Primary Language (optional*): Spoken:				Written:			-
Ethnicity (optional*):	ack American I	ndian/Alaska Nati	ve 🔾				
Previous coverage: OYes Previous ca	rrier:			_ Effective from:		To:	-
HMO only—Physician (PCP) Last		First			Phys #		Current Patient?
OB/GYN Last		First			Phys#		Current Patient?

E. DEPENDENT INFO

Note: Make sure you sign and date the application on the next page.

E. DEPENDENT INFO Cont'd					
8d. Last	First	M.I.	SSN (Required)	Date of Birth	Medical Add <i>or</i> Delete
Rel: <i>Son Daughter</i>	○ Full-time student?	\bigcirc D	isabled	End-Stage Renal Disease	\circ
Medicare number:	Part A effective date:		Pa	art B effective date:	 Delta Dental
	efit through a New York Health Ber			lone dental coverage that provides a alone dental plan offered outside the	Add or Delete
If you answered "yes," please provid	e the name of the company issuing	g the stand-al	one dental covera	nge	
If you answered "no," we will provide	you coverage of the pediatric dental	essential hea	alth benefit. Additi	onal cost may apply. Ask your employer	r for rate information
Primary Language (optional*): Spoke	n:		Written:		
Ethnicity (optional*):	Black American Indian/Alaska	Native O	Asian/Pacific Islan	der OHispanic/Latino Other	
Previous coverage: O Yes Previous	carrier:		_ Effective from: _	To:	
HMO only—Physician (PCP) Last	First			Phys #	Current Patient?
OB/GYN Last	First			Phys #	Current Patient?
F. OTHER INSURANCE	_	-	_	_	
Do you, your spouse, or any of your depe	ndents have any other medical insura	nce that will be	e maintained in add	ition to CDPHP? Yes: If yes, complete	te below. ONo
9. Policyholder name	Policy #	I	Insurance carrier	Employer name	
Date of birth:	Address:				
Effective date:	Coverage type:	○ Hospital	○Medical	Orug Opental Ovision	
Covered Individuals—Check all that app	ly Self Spouse O	Dependents			
	I hereby represent that all inf read the important informati			hereon is true and complete to so	the best of my
	onceals for the purpose of misleadi	ing, informati	on concerning an	application for insurance or statemen y fact material thereto, commits a frauc e of the claim for each such violation.	
10. Applicant's Signature:				11. Date:	

IMPORTANT INFORMATION

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® member services department at (518) 641-3700 or 1-800-777-2273. Thank you for choosing CDPHP for your health care coverage.

Your signature on this application hereby affirms the following:

On behalf of myself and any dependents listed, I hereby apply for coverage under the Master Group Contract (health and/or dental, as the case may be) issued to my employer by Capital District Physicians' Health Plan, Inc. (HMO products) and/or CDPHP Universal Benefits, Inc. (CDPHP UBI) (EPO/PPO/HD products) and/or Delta Dental of New York, 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/or Delta Dental of New York, Inc., 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.

Delta Dental Service Plans are underwritten and administered by Delta Dental of New York, Inc.



Delta Dental of New York One Delta Drive Mechanicsburg, PA 17055 1-800-932-0783 TTY/TDD 1-888-373-3582 www.deltadentalins.com

A REGISTERED MARK OF DELTA DENTAL PLANS ASSOCIATION

*You are not required to answer. This information is important, however, as it helps us understand the diversity of our membership.

Form # 02-0010-2016

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