PLEASE PRINT. *For address and/or primary care physician changes call (518) 641-3700, 1-800-777-2273, or visit www.cdphp.com* USE BLACK INK ONLY.
Note: You cannot purchase an individual plan if you are enrolled in Medicare.

Individual Plans Enrollment Application/Change Form

6 Wellness Way
Latham, NY 12110
(518) 641-3700 or 1-800-777-2273

A. EXPLANATION *(CHECK ALL THAT APPLY)*

Reason for applying (Qualifying life event)

New Enrollment:
◯ Open Enrollment
◯ Birth of a Child
◯ Loss of Coverage
◯ Marriage
◯ Court Order
◯ Other: *(Reason and date of qualifying event)* ______

Change Enrollment:
◯ Termination
◯ Member Requested
◯ Remove Dependents Only
◯ Deceased
◯ Other: *(Reason and date of qualifying event)* ______

B. COVERAGE INFORMATION *(CHECK ALL THAT APPLY)*

Requested Effective date: ______ Is this for Child-Only coverage? ◯ No ◯ Yes (If yes, you must select a Standard plan.)

If Yes, indicate name of Responsible Adult: ______

Do you have other children enrolled in a CDPHP Child-Only plan? If so, please list names: ______

Please select your plan and applicable riders.

◯ HDHMO HSA Qualified 44 Bronze*
◯ HDHMO HSA Qualified Bronze Standard*
◯ HMO Hybrid 13 Platinum
◯ HMO Copayment 10 Platinum Standard
◯ HDHMO HSA Qualified 33 Silver*
◯ HMO Copayment 30 Silver Standard
◯ HDHMO HSA Qualified 45 Bronze*
◯ HDHMO Non-Qualified 60 Bronze
◯ HMO Triple Zero 24 Gold
◯ HMO Copayment 20 Gold Standard
◯ HMO Copayment 14 Platinum
◯ HDHMO HSA Qualified 35 Silver*

Optional riders:
◯ Dependent through Age 29 Coverage

*HealthEquity Individual HSA ◯ Yes ◯ No

(The Custodial Agreement for this account will be sent to you under separate cover.)

C. SUBSCRIBER INFO

For **HMOs only,** you and each dependent **MUST** select a Primary Care Physician (PCP). Member may also choose one OB/GYN. Also indicate if a member is a current patient and get the Physician # and Office Location from the provider directory or at www.cdphp.com.

1. Last Name ______ First Name ______ M.I. ______

4. Telephone: Primary ______ Secondary ______

2a. Street Address ______ Apt. # ______

5. E-mail Address ______

2b. City ______ State ______ ZIP ______

6. Social Security Number **(Required)** ______

3a. Mailing Address ◯ Check here if same as street address ______ Apt. # ______

7. Date of Birth ______

3b. City ______ State ______ ZIP ______

Gender: ◯ *M* ◯ *F* ◯ *Non-Binary*

Medical ◯ **Add** **or** ◯ **Delete**

The following are optional but help us understand the diversity of our membership.

Primary Language *(optional):* Spoken: ______ Written: ______

Ethnicity (optional): ◯ Hispanic or Latino ◯ Not Hispanic or Latino

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," we will provide you coverage of the pediatric dental essential health benefit. Additional cost may apply. Ask your employer for rate information.

Previous coverage: ◯ Yes Previous carrier: ______ Effective from: ______ To: ______

HMO only—Physician (PCP) Last ______ First ______ Phys # ______ Current Patient? ◯

OB/GYN Last ______ First ______ Phys # ______ Current Patient? ◯

 Continued on page 2

D. DEPENDENT INFO

For **HMOs only,** you and each dependent **MUST** select a Primary Care Physician (PCP). Member may also choose one OB/GYN. Also indicate if a member is a current patient and get the Physician # and Office Location from the provider directory or at www.cdphp.com.

8a. Last Name ____ First Name ____ M.I. ____ SSN ***(Required)*** ____ Date of Birth ____ **Medical Add *or* Delete** ◯ ◯

Rel: ◯ Spouse ◯ Domestic Partner Gender: ◯ *M* ◯ *F* ◯ *Non-Binary*

Telephone: Home ____ Work ____ Mobile ____ E-mail Address ____

The following are optional but help us understand the diversity of our membership.

Primary Language *(optional):* Spoken: ____ Written: ____

Ethnicity (optional): ◯ Hispanic or Latino ◯ Not Hispanic or Latino

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," we will provide you coverage of the pediatric dental essential health benefit. Additional cost may apply. See rate sheet for your county.

Previous coverage: ◯ Yes Previous carrier: ____ Effective from: ____ To: ____

HMO only—Physician (PCP) Last ____ First ____ Phys # ____ Current Patient? ◯

OB/GYN Last ____ First ____ Phys # ____ Current Patient? ◯

8b. Last Name ____ First Name ____ M.I. ____ SSN ***(Required)*** ____ Date of Birth ____ **Medical Add *or* Delete** ◯ ◯

Rel: ◯ Child ◯ Other Gender: ◯ *M* ◯ *F* ◯ *Non-Binary*

Telephone: Home ____ Work ____ Mobile ____ E-mail Address ____

The following are optional but help us understand the diversity of our membership.

Primary Language *(optional):* Spoken: ____ Written: ____

Ethnicity (optional): ◯ Hispanic or Latino ◯ Not Hispanic or Latino

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," we will provide you coverage of the pediatric dental essential health benefit. Additional cost may apply. See rate sheet for your county.

Previous coverage: ◯ Yes Previous carrier: ____ Effective from: ____ To: ____

HMO only—Physician (PCP) Last ____ First ____ Phys # ____ Current Patient? ◯

OB/GYN Last ____ First ____ Phys # ____ Current Patient? ◯

8c. Last Name ____ First Name ____ M.I. ____ SSN ***(Required)*** ____ Date of Birth ____ **Medical Add *or* Delete** ◯ ◯

Rel: ◯ Child ◯ Other Gender: ◯ *M* ◯ *F* ◯ *Non-Binary*

Telephone: Home ____ Work ____ Mobile ____ E-mail Address ____

The following are optional but help us understand the diversity of our membership.

Primary Language *(optional):* Spoken: ____ Written: ____

Ethnicity (optional): ◯ Hispanic or Latino ◯ Not Hispanic or Latino

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," we will provide you coverage of the pediatric dental essential health benefit. Additional cost may apply. See rate sheet for your county.

Previous coverage: ◯ Yes Previous carrier: ____ Effective from: ____ To: ____

HMO only—Physician (PCP) Last ____ First ____ Phys # ____ Current Patient? ◯

OB/GYN Last ____ First ____ Phys # ____ Current Patient? ◯

Continued on page 3

D. DEPENDENT INFO Cont'd

8d. Last Name ______ First Name ______ M.I. ______ SSN ***(Required)*** ______ Date of Birth ______ **Medical Add *or* Delete** ◯ ◯

Rel: ◯ Child ◯ Other Gender: ◯ *M* ◯ *F* ◯ *Non-Binary*

Telephone: Home ______ Work ______ Mobile ______ E-mail Address ______

The following are optional but help us understand the diversity of our membership.

Primary Language *(optional):* Spoken: ______ Written: ______

Ethnicity (optional): ◯ Hispanic or Latino ◯ Not Hispanic or Latino

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

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If you answered "no," we will provide you coverage of the pediatric dental essential health benefit. Additional cost may apply. See rate sheet for your county.

Previous coverage: ◯ Yes Previous carrier: ______ Effective from: ______ To: ______

HMO only—Physician (PCP) Last ______ First ______ Phys # ______ Current Patient? ◯

OB/GYN Last ______ First ______ Phys # ______ Current Patient? ◯

E. OTHER INSURANCE

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

9. Policyholder Name ______ Policy # ______ Insurance carrier ______ Employer name ______

Date of Birth ______ Address ______

Effective date: ______ Coverage type: ◯ Hospital ◯ Medical ◯ Drug ◯ Dental ◯ Vision

Covered Individuals—Check all that apply ◯ Self ◯ Spouse ◯ Dependents

Note: Make sure you sign and date the application below.

F. 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 last page 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.

10. Applicant's Signature: ______ 11. Date: ______

(For Child-Only Plans: Responsible Adult Signature.)

IMPORTANT INFORMATION

Failure to complete any sections will result in a processing delay of your application, member ID cards and, claims payment.

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 Individual Contract issued by Capital District Physicians' Health Plan, Inc. and/or CDPHP Universal Benefits,® Inc. (CDPHP UBI), 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 Individual 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 understand that unresolved grievances are subject to the procedure specified in the Individual Contract.

CDPHP COMPANIES
Capital District Physicians' Health Plan, Inc.
CDPHP Universal Benefits,® Inc.
Capital District Physicians' Healthcare Network, Inc..

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

A REGISTERED MARK OF DELTA DENTAL PLANS ASSOCIATION

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