



Enrollment Application/Change Form

Please clearly **PRINT** all information

P.O. Box 710, Buffalo, NY 14231-0710 independenthealth.com

KEY

† Supporting documentation required

‡ If allowed by plan; supporting documentation may be required

§ Must include date of qualifying event

Employer Admin. Initials:	Date:
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To avoid a delay in your health insurance coverage, please be sure ALL SECTIONS ARE COMPLETED

What type of insurance are you applying for (select one)?

- Employer Group – actively employed COBRA Individual (application must include payment and supporting documentation)

A Coverage Information

Name of Employer (not needed for individuals not associated with employer group)

Account Number	Sub Account (if applicable)	Plan Name
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Effective Date (date the coverage for this applicant should be effective)	Employee ID/Division/Union/Class (if applicable)
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Failure to include a date in this field may result in a delay in your coverage.

B Qualifying Event Information

Enroll/Add Coverage (enter date and select reason below) **Date of Qualifying Event:** ____/____/____ (ex: date of hire)

Check One:

- | | | | |
|--|--|---|-------------------------------------|
| <input type="checkbox"/> Open Enrollment | <input type="checkbox"/> New Hire § | <input type="checkbox"/> Newborn § | <input type="checkbox"/> Marriage § |
| <input type="checkbox"/> Relocated/transfer § | <input type="checkbox"/> Adoption/Guardianship † | <input type="checkbox"/> Involuntary Loss of Coverage § | |
| <input type="checkbox"/> Change in Employment Status § | <input type="checkbox"/> Domestic Partner ‡ | <input type="checkbox"/> Enrolling COBRA coverage | |
| <input type="checkbox"/> Other † _____ | | | |

Disenroll/Cancel Coverage (enter date and select reason below) **Effective date of cancellation:** ____/____/____

Check One:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Terminate Employment | <input type="checkbox"/> Deceased | <input type="checkbox"/> Dependent Max age reached | <input type="checkbox"/> Divorced † |
| <input type="checkbox"/> Moved out of area | <input type="checkbox"/> No longer eligible | <input type="checkbox"/> Nonpayment | <input type="checkbox"/> Other coverage |
| <input type="checkbox"/> Layoff/Strike | <input type="checkbox"/> Cancel coverage for entire family | <input type="checkbox"/> Cancel coverage for all dependents only | |
| <input type="checkbox"/> Cancel coverage for the following dependents only: _____ | | | |

Change(s) to existing plan (enter date and select reason below) **Effective date of change:** ____/____/____

Check One:

- | | | | | |
|----------------------------------|------------------------------------|---|------------------------------------|---|
| <input type="checkbox"/> Address | <input type="checkbox"/> Phone No. | <input type="checkbox"/> Marital status | <input type="checkbox"/> Last Name | <input type="checkbox"/> New Employment type* |
|----------------------------------|------------------------------------|---|------------------------------------|---|

***If new employment type check one box below:**

- | | | | | |
|---|--------------------------------|-----------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Active | <input type="checkbox"/> COBRA | <input type="checkbox"/> Inactive | <input type="checkbox"/> Surviving Insured | <input type="checkbox"/> TEFRA/DEFRA |
| <input type="checkbox"/> Retired <i>Check here if employee is changing to retired status.</i> | | | | |

Employee/Individual Social Security Number

Dependent #1

† Supporting documentation required ‡ If allowed by plan; supporting documentation required

Dependent SSN
Relationship to Employee/Individual
 Spouse Child Grandchild ‡ Legal ward † Domestic Partner ‡ Other † _____
(please specify)

Dependent/Spouse Last Name **First Name** **Middle Initial** **Date of Birth (MM/DD/YYYY)**
() ()

Gender **Mobile Phone No. (include area code)** **Home Phone No. (include area code)**

Email address Primary Language: (if other than English)
Primary Care Physician (refer to Find A Doctor tool at independenthealth.com/findadoctor)

Provider Name Provider Address Are you a current patient of this physician? (Y or N)

Dependent #2

† Supporting documentation required ‡ If allowed by plan; supporting documentation required

Dependent SSN
Relationship to Employee/Individual
 Spouse Child Grandchild ‡ Legal ward † Domestic Partner ‡ Other † _____
(please specify)

Dependent/Spouse Last Name **First Name** **Middle Initial** **Date of Birth (MM/DD/YYYY)**
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Gender **Mobile Phone No. (include area code)** **Home Phone No. (include area code)**

Email address Primary Language: (if other than English)
Primary Care Physician (refer to Find A Doctor tool at independenthealth.com/findadoctor)

Provider Name Provider Address Are you a current patient of this physician? (Y or N)

Dependent #3

† Supporting documentation required ‡ If allowed by plan; supporting documentation required

Dependent SSN
Relationship to Employee/Individual
 Spouse Child Grandchild ‡ Legal ward † Domestic Partner ‡ Other † _____
(please specify)

Dependent/Spouse Last Name **First Name** **Middle Initial** **Date of Birth (MM/DD/YYYY)**
() ()

Gender **Mobile Phone No. (include area code)** **Home Phone No. (include area code)**

Email address Primary Language: (if other than English)
Primary Care Physician (refer to Find A Doctor tool at independenthealth.com/findadoctor)

Provider Name Provider Address Are you a current patient of this physician? (Y or N)

Certification and Consent – Signature REQUIRED

I certify that the information given on this application is current, true and correct to the best of my knowledge and I have read and agree to this statement. I understand that this application and my spouse or eligible dependent’s subsequent receipt of health care services are subject to the terms of the applicable coverage document. I understand that if I enroll in a health coverage product through my employer, my employer is responsible for remitting premium payments on my behalf, or in the case of self-insured employers, my employer is responsible for paying my health care claims. I consent to any person or institution that shall have rendered health services to me or to any member of my family under the applicable coverage document to make available any photographs, records or information regarding such services to Independent Health¹. Any information received or generated by Independent Health shall be kept confidential and secure as required by applicable laws, rules, regulations or contract. I also consent to Independent Health disclosing my health information or the health information of any member of my family for Independent Health’s or a provider, health plan, health care clearinghouse or other covered entity’s treatment, payment or health care operations as permitted by applicable laws, rules and regulations. This consent shall remain in effect until revoked by me in writing or a maximum of 24 months from this 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 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.

X Employee/Individual Signature

Date:

¹“Independent Health” means Independent Health Association, Inc. or Independent Health Benefits Corporation for members who enroll in a health coverage product through their employers or on their own. For an individual whose employer self-insures his or her health coverage, the term “Independent Health” means Independent Health Corporation, a third party administration company.

