PLEASE PRINT. *For address and/or primary care physician changes call (518) 641-3100, 1-877-724-2579, or visit www.cdphp.com* USE BLACK INK ONLY.

Enrollment Application/ Change Form

Capital District Physicians' Healthcare Network, Inc.
500 Patroon Creek Blvd.
Albany, NY 12206-1057
(518) 641-3100 or 1-877-724-2579

EMPLOYER USE ONLY

Date Hired (MM/DD/YY) *(required)* _____ ◯ Full-time ◯ Part-time (20 hours or less/week)

Date coverage is effective _____ ◯ Active ◯ COBRA

◯ Retiree 65 or older ◯ Retiree 55–65 ◯ Retiree Under 55

Date of status change _____ Employer Name_____

◯ Part- to full-time ◯ Union to non-union ◯ Other _____

Group/Subgroup #: _____ Class #: _____

Grp Admin Initials *(required)* _____

A. EXPLANATION Check all that apply

◯ New Hire ◯ Open Enrollment ◯ Loss of Coverage ◯ Marriage ◯ Birth ◯ Change in Student Status ◯ Dependent to 29

◯ Name/Address Change ◯ Court Order

◯ **COBRA**—*Reason:* ◯ Left Employ/Retirement ◯ Divorce/Legal Separation ◯ Death of Spouse ◯ Dependent Reached Max Age ◯ Loss of Student Status

◯ **Termination**—*Reason:* ◯ Employment Terminated ◯ Remove Dependents Only ◯ Deceased ◯ Other_____

B. COVERAGE INFORMATION

Product Type: ◯ HMO ◯ HDHMO ◯ EPO ◯ HDEPO ◯ PPO ◯ HDPPO

PCP Copay Amt: $ _____ Specialist Copay Amt: $ _____ % Coins: _____ Deduct. Amt: $ _____ ◯ **Drug Coverage** ◯ **Dental Coverage**

Dental Coverage: ◯ Single ◯ Employee/Children ◯ Employee/Spouse ◯ Family

C. CONSUMER-DIRECTED HEALTH PLANS

I am participating in a CDPHP-administered:

◯ Flexible Spending Account ◯ Health Reimbursement Account ◯ Health Savings Account ◯ Not Applicable

D. SUBSCRIBER INFO

For **HMOs only**, you and each dependent **MUST** select a Primary Care Physician (PCP). Females 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. **For all other products, include copy of your HIPAA certificate. If you have Medicare Parts A and B, include a copy of your Medicare card.**

1. Last Name _____ First Name _____ M.I. _____ 4. Telephone: Home _____ Work _____

2. Street Address _____ Apt. # _____ 5. E-mail Address _____

3. City _____ State _____ ZIP _____ 6. Employer Name _____

7. Social Security Number ***(Required)*** _____ Date of Birth _____ Add *or* Delete ◯ ◯

Sex: ◯ *M* ◯ *F* ◯ Disabled ◯ End-Stage Renal Disease

Medicare number: _____ Part A effective date:_____ Part B effective date: _____

Primary Language: _____

Ethnicity: ◯ White ◯ Black ◯ American Indian/Alaska Native ◯ Asian/Pacific Islander ◯ Hispanic/Latino ◯ Other

Previous coverage: ◯ *Yes* Previous carrier: _____ Effective from: _____ To: _____

HMO only—Physician (PCP) Last _____ First _____ M.I. _____ Office location _____ Phys # _____ Current Patient? ◯

OB/GYN Last _____ First _____ M.I. _____ Office location _____ Phys # _____ Current Patient? ◯

E. DEPENDENT INFO

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

Rel: ◯ *Spouse* ◯ *Other* Sex: ◯ *M* ◯ *F* ◯ Disabled ◯ End-Stage Renal Disease

Medicare number: _____ Part A effective date:_____ Part B effective date: _____

Primary Language: _____

Ethnicity: ◯ White ◯ Black ◯ American Indian/Alaska Native ◯ Asian/Pacific Islander ◯ Hispanic/Latino ◯ Other

Previous coverage: ◯ *Yes* Previous carrier: _____ Effective from: _____ To: _____

HMO only—Physician (PCP) Last _____ First _____ M.I. _____ Office location _____ Phys # _____ Current Patient? ◯

OB/GYN Last _____ First _____ M.I. _____ Office location _____ Phys # _____ Current Patient? ◯

Continued on page 2

E. DEPENDENT INFO *Cont'd*

For **HMOs only**, you and each dependent **MUST** select a Primary Care Physician (PCP). Females 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. **For all other products, include copy of your HIPAA certificate. If you have Medicare Parts A and B, include a copy of your Medicare card.**

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

Rel: ◯ *Son* ◯ *Daughter* ◯ *Full-time student?* ◯ Disabled ◯ End-Stage Renal Disease

Medicare number: _____ Part A effective date: _____ Part B effective date: _____

Primary Language: _____

Ethnicity: ◯ White ◯ Black ◯ American Indian/Alaska Native ◯ Asian/Pacific Islander ◯ Hispanic/Latino ◯ Other

School name *(if student)* _____ Expected date of graduation _____ School address *(City, State, ZIP)* _____

Previous coverage: ◯ *Yes* Previous carrier: _____ Effective from: _____ To: _____

HMO only—Physician (PCP) Last _____ First _____ M.I. _____ Office location _____ Phys # _____ Current Patient? ◯

OB/GYN Last _____ First _____ M.I. _____ Office location _____ Phys # _____ Current Patient? ◯

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

Rel: ◯ *Son* ◯ *Daughter* ◯ *Full-time student?* ◯ Disabled ◯ End-Stage Renal Disease

Medicare number: _____ Part A effective date: _____ Part B effective date: _____

Primary Language: _____

Ethnicity: ◯ White ◯ Black ◯ American Indian/Alaska Native ◯ Asian/Pacific Islander ◯ Hispanic/Latino ◯ Other

School name *(if student)* _____ Expected date of graduation _____ School address *(City, State, ZIP)* _____

Previous coverage: ◯ *Yes* Previous carrier: _____ Effective from: _____ To: _____

HMO only—Physician (PCP) Last _____ First _____ M.I. _____ Office location _____ Phys # _____ Current Patient? ◯

OB/GYN Last _____ First _____ M.I. _____ Office location _____ Phys # _____ Current Patient? ◯

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

Rel: ◯ *Son* ◯ *Daughter* ◯ *Full-time student?* ◯ Disabled ◯ End-Stage Renal Disease

Medicare number: _____ Part A effective date: _____ Part B effective date: _____

Primary Language: _____

Ethnicity: ◯ White ◯ Black ◯ American Indian/Alaska Native ◯ Asian/Pacific Islander ◯ Hispanic/Latino ◯ Other

School name *(if student)* _____ Expected date of graduation _____ School address *(City, State, ZIP)* _____

Previous coverage: ◯ *Yes* Previous carrier: _____ Effective from: _____ To: _____

HMO only—Physician (PCP) Last _____ First _____ M.I. _____ Office location _____ Phys # _____ Current Patient? ◯

OB/GYN Last _____ First _____ M.I. _____ Office location _____ Phys # _____ Current Patient? ◯

F. OTHER INSURANCE

Do you, your spouse, or any of your dependents have any other medical insurance that will be maintained in addition to your employer sponsored plan?

◯ 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 on the next page.

Continued on page 3

G. 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.

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 CDPHN® member services department at (518) 641-3100 or 1-800-724-2579. Thank you for choosing CDPHN 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 (health and/or dental, as the case may be) offered by my employer's plan and administered by Capital District Physicians' Healthcare Network, Inc. and/or Delta Dental of New York, Inc.

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 CDPHN 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 plan description.

Capital District Physicians' Healthcare Network, 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