EmblemHealth

TRANSACTION FORM FOR GROUP ACCOUNTS

I. SUBSCRIBER INFORMATION

Last Name	First Name	M.I.	Sex	Social Security Number

Street Address	Apt.	City	State	ZIP Code

Were you ever a member of EmblemHealth? NO YES	**Marital Status:** Single Married	**Birth Date:**	Phone Number:	Email Address:

Applicant's hours worked per week: ☐ at least 30 hours ☐ less than 30 hours ☐ COBRA

Type of Coverage: ☐ Individual ☐ Family

Note: If electing Young Adult Coverage, please submit a completed Young Adult Election Form.

Choose one Option   Standard Option   Buy-Up Option

II. ENROLLMENT INFORMATION — IF YOU ARE ENROLLING YOUR SPOUSE/DP AND/OR CHILDREN, PLEASE LIST EACH ONE BELOW — SEE ELECTION OF COVERAGE FOR ELIGIBILITY

Note: A birth/marriage certificate or 1040 Form will be required for spouse/dependents with different last name.

Last Name (if different) First Name	Social Security Number	Sex	Relationship	Birth Date Mo.	Day	Yr.	✓ if Disabled[1]	Primary Care Physician Name/ID Number (Not required for EPO/PPO members)	OB/GYN Selection Name/ID Number (Optional)
DEPENDENT			☐ Spouse ☐ DP ☐ Child						
DEPENDENT			☐ Child						
DEPENDENT			☐ Child						

[1] For dependent adult children incapable of self-sustaining employment, please see Section A on the back side of this form to check the appropriate "Add Dependent" box, and follow the instruction for required documentation.

Your signature is required to process this form. Your signature attests that you have read the reverse side 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 material fact associated with such application commits a fraudulent insurance act. Such act is a crime, and will be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Applicant must sign here: ______________________________ **Date:** ______________

III. EMPLOYER INFORMATION — THIS SECTION TO BE COMPLETED BY EMPLOYER/CONTRACTOR GROUP

Name of Group:	Group Number:	☐ EmblemHealth ☐ GHI ☐ GHI HMO ☐ HIP Plan Name: ______________		If you selected a small group metal plan, please check which type: ☐ Gold ☐ Silver ☐ Bronze
Requested Effective Date: Medical: ________ Dental: ________	Hire Date:	Waiting Period:	Date Submitted:	Approved By: (Group Plan Administrator)

Instructions to Benefit Administrators or Group Representatives: For groups with 50 employees or fewer, you MUST complete Section A on the reverse side of this form. Required documentation MUST be attached to this Transaction Form to be processed.