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Individual & Family Health Insurance Application/Change Form

For Internal Use

- Please print clearly and complete all sections that apply to you
- Additional instructions are included

FOR INTERNAL USE ONLY

HIOS ID# _____

EC _____

Section 1: Your Information (REQUIRED)

_____ Subscriber ID# _____

Last Name First Name MI (For changes and cancellations)

Gender: ☐Female ☐Male ☐Gender X

Social Security # ** _____ Birthdate ____/____/____

Street Address (Physical address only no PO Box) City State Zip County (Where taxes are paid)

Mailing Address (if different) City State Zip

Billing Address (if different) City State Zip

Phone 1 (primary) Phone 2 (secondary)

Email

You must fill out the following section: Would you like to be added to the Donate Life Registry? ☐ Yes ☐ Skip this question

Section 2: What do you need to do?

☐ Enroll in a new plan ☐ Add a dependent(s) ☐ Change current coverage

☐ Cancel Coverage ☐Remove a dependent ☐ Change name or address

Section 3: If enrolling in a new plan, who do you need coverage for?

☐Self Only ☐Self & Spouse/Domestic Partner ☐Self & Child(ren) ☐Family ☐Child(ren) Only

Effective Date ____/____/____

Section 4: If canceling coverage, who are you canceling coverage for?

WHO	NAME	BIRTH YEAR	CANCEL DATE
SUBSCRIBER			____/____/____
DEPENDENT			____/____/____
DEPENDENT			____/____/____
DEPENDENT			____/____/____
DEPENDENT			____/____/____
DEPENDENT			____/____/____

*Notice must be received at least 14 days ***prior to*** the cancel date
**Additional documentation may be requested

Why are you canceling coverage?

☐ Subscriber's request ☐ Deceased ☐ Divorce**

☐ Moved out of area

Other coverage: ☐ Through spouse ☐ Through Medicare

☐ Through Medicaid** ☐ Other _____

Section 5: Special Enrollment Period

If you are applying outside of the annual Open Enrollment Period, please check one of the events below that applies to you. The Special Enrollment Period begins on the date of the event checked and continues for 60 days.

☐ Adoption ☐Birth ☐Change in employment status ☐Change to new employer that does not offer insurance ☐Death
☐ Dependent reached maximum age of coverage ☐Divorce/annulment/legal separation ☐ Domestic Partnership
☐ Domestic Violence ☐Loss of coverage ☐Marriage ☐Moved in/out of service area

☐ Pregnancy ☐Other _____ **Date of Event** _____, _____, _____

Section 6: Plan options

(A) You may only select one

☐ Platinum Standard; ☐ Gold Standard; ☐ Silver Standard; ☐ Bronze Standard; ☐ Bronze Standard HSA;
☐ Platinum Select; ☐ Gold Select; ☐ Silver Select; ☐ Bronze Select; ☐ Bronze Secure Plus 3;
☐ Silver Select 2; ☐ [Other Plan(s)]

(B) Add Dependent Coverage to 29?

☐ Yes ☐ No

(C)Add Child Only Coverage?

Only available if you selected a Standard plan option in Column A. If selected your child will be covered until age 21.

☐ Yes ☐ No

Section 7: Other coverage information (Must be completed – you may be contacted for additional information)

What other coverage do you or your family have? ☐Medicare ☐Medicaid ☐Medical ☐Dental ☐None (move to Section 9)

What is the effective date of the other coverage? ☐ Medical: _____ , _____ , _____ ☐ Dental: ____ , ____ , _____

What is the name of the other carrier(s)? _____ _____

Are you keeping the coverage? ☐Yes ☐No

If no, when will the coverage end? ☐ Medical: _____ , _____ , _____ ☐ Dental: _____ , ____ , _____

Policyholder's name _____ ID#(s) _____

Did the insurance cover ☐Insured ☐Insured and family

Section 8: Information about who you would like coverage for

☐ Spouse ☐Domestic Partner ☐Dependent Child ☐Adult Disabled Dependent ☐Child Only ☐Other _____

Birthdate _____ Gender: ☐Female ☐Male ☐Gender X

Last Name (if different) | First Name | MI | Social Security #

☐ Spouse ☐Domestic Partner ☐Dependent Child ☐Adult Disabled Dependent ☐Child Only ☐Other _____

Birthdate _____ _____ _____ Gender: ☐Female ☐Male ☐Gender X

Last Name (if different) | First Name | MI | Social Security #

☐ Spouse ☐Domestic Partner ☐Dependent Child ☐Adult Disabled Dependent ☐Child Only ☐Other _____

Birthdate _____, _____, _____ Gender: ☐Female ☐Male ☐Gender X

Last Name (if different) | First Name | MI | Social Security #

☐ Spouse ☐Domestic Partner ☐Dependent Child ☐Adult Disabled Dependent ☐Child Only ☐Other ____________________

Birthdate ________, _____, ___________ Gender: ☐Female ☐Male ☐Gender X

Last Name (if different) ____ First Name ____ MI ____ Social Security # ** ____

☐ Spouse ☐Domestic Partner ☐Dependent Child ☐Adult Disabled Dependent ☐Child Only ☐Other ____________________

Birthdate ________ _____ ___________ Gender: ☐Female ☐Male ☐Gender X

Last Name (if different) ____ First Name ____ MI ____ Social Security # ** ____

☐ Spouse ☐Domestic Partner ☐Dependent Child ☐Adult Disabled Dependent ☐Child Only ☐Other ____________________

Birthdate ________, _____, ___________ Gender: ☐Female ☐Male ☐Gender X

Last Name (if different) ____ First Name ____ MI ____ Social Security # ** ____

Section 9: Third party administrator must complete this section (Broker, Agent, Internal Sales, and Certified Application Counselor (CAC)/ Marketplace Facilitated Enroller (MFE) – If a broker, license # for the agency must be completed to be eligible for commission)

Name of Broker/Agent/CAC/MFE/Person assisting ______________________________

Agency Name (if applicable ______________________________

Agency License # (if applicable) ____________ Agency Tax ID (if applicable) ______________________________

Section 10: Release – You must sign and date this form to be eligible for health insurance.

Pursuant to federal rules that implement the Affordable Care Act, individual health insurance policies must be written on a calendar year basis. This means that if your effective date of coverage is a date later than January 1st of a year, the initial term of coverage for your policy will be for less than a full year and will end on December 31st of the same year. Please be advised that all benefits and cost sharing under your policy, including the full annual deductible, apply to the partial year of coverage. I acknowledge and agree that by signing this enrollment form and subsequently accepting services, I and everyone else who is covered under the contract you issue is bound by the terms and conditions of the contract applicable to my coverage. This includes, without limitation, the terms and conditions regarding the receipt and release of medical records and information. I make this acknowledgement and agreement on behalf of myself and each other person who accepts coverage under the terms of the contract applicable to my coverage (who may include, for example my spouse and my eligible family dependents).

I hereby accept responsibility for payment of any portion of the premium.

I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

I understand that if I elect Exclusive Provider Organization (EPO) coverage, except in an emergency, all care must be provided by medical providers who participate with the EPO and I will not receive benefits for care that I receive from providers who do not participate with the EPO.

I have thoroughly read, understand, and agree to comply with the terms of this Release section.

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.

Subscriber Signature ______________________________ **Date** ____________

Instructions for completing Individual & Family Health Insurance Application

Section 1: The entire section is REQUIRED to be completed by the subscriber. For child only plans, the parent or guardian's information is REQUIRED in this section. **We are required to ask for your social security number in order to meet our reporting obligations under the Affordable Care Act.
Health Equity: Health care should meet the needs of everyone—no matter who you are, where you live, or who you love. To learn more about health equity and view our privacy policy, visit UniveraHealthcare.com/HealthEquity.
Donate Life Registry: By checking 'Yes' and signing this application, you are consenting to enroll in the New York State Donate Life Registry (Registry). To modify your gift or withdraw from the Registry go to: donatelife.ny.gov or call the Registry at 1-866- NY-DONOR.

Section 2: Select the box that describes what you need to do regarding health insurance coverage.

Section 3: Select the box that describes who you need coverage for. Please complete section 9 if you select any box other than self only. Effective dates are determined based upon the date you request provided you are enrolling by the 25th of the month to be effective the first of the following month. Retroactive requests for coverage and other effective dates may be allowed for certain qualifying events.

Section 4: If you are canceling coverage, select who you are canceling coverage for and the date the coverage will cancel. Then select your reason for canceling.

Section 5: There are certain life changes that make you eligible for a Special Enrollment Period (SEP) such as having a baby, getting married or your coverage under another plan is ending. Select the event that applies to you and include the date of the event. You may be required to provide documentation of certain events. *Please contact our dedicated Insurance Advisors at 1-888-400-9907 for a list of documentation required.

Section 6: Column A – Select one plan option only. Column B – Select this option if you would like to purchase additional coverage for dependents age 26 – 29. Additional information may be requested. Dependents will be covered until end of the month the Dependent turns 30 years of age (cannot be selected in conjunction with a Child-Only plan). Column C – Select a child only plan if you need coverage for a child or children up to age 21.

Section 7: Please include accurate information in this section. This could affect the processing of your application and/or claims. Medicaid is a public aid program for those with a limited income. This is not the same as Medicare.
If you are Medicare eligible and enrolled in Medicare Part A and/or Medicare Part B, do not complete this application. Please contact one of our dedicated Insurance Advisors at 1-888-400-9907 for the Supplemental Medicare Eligible Enrollment Form or a Medicare Advantage plan enrollment application

Section 8: Please include information about all the people for whom you would like coverage. Use an additional application if more than five people need coverage. There are additional eligibility and documentation requirements for coverage of dependents noted with an asterisk (*) below. Qualified guidelines for coverage include:

- A legal spouse*/domestic partner* (An ex-spouse no longer qualifies as of the date court documents are stamped and filed with the court)
- Dependent under the age of 26 – Natural, adopted* or stepchild
- Child (ren) Only coverage is available for children up to age 21
- Disabled Dependents* over the dependent age
- Dependents by legal guardianship*
- *Please contact our dedicated Insurance Advisors at 1-888-400-9907 or visit our website UniveraHealthcare.com for information and any required form(s). Eligibility Requirements are outlined in the Member Contract.

**We are required to ask for your social security number in order to meet our reporting obligations under the Affordable Care Act.

Section 9: This section is to be completed by the Third-Party Administrator who may be assisting you with your enrollment process. A third-party administrator can be an authorized agent or broker and to the extent permitted by the Federal and State law and regulation, any other third-party assistors. If you are not working with a Third-Party Administrator, you can disregard this section.

Section 10: Subscriber signature and date are required in this section.

YOUR PREMIUM PAYMENT MUST BE INCLUDED WITH THE APPLICATION

Please mail application and payment to:

Enrollment Operations
PO Box 31790
Rochester, NY 14603-1790

If you have questions, please contact our dedicated Insurance Advisors at 1-888-400-9907
Learn about exclusive member benefits at UniveraHealthcare.com/FindAPlan