Independent Health℠

PO BOX 710
Williamsville, NY 14231-0710
www.independenthealth.com

1. Please check one: ☐ GROUP ENROLLMENT APPLICATION ☐ CHANGE FORM ☐ COBRA ELECTION

2. EFFECTIVE DATE ____ / ____ / ____ (Add, Change or Cancellation) **GROUP #** _____ **PLAN #** _____ (Please Reference Benefit Summary)

Administrator Approval: *REQUIRED FOR PROCESSING*
Initials _____
Today's Date _____

3. *For New Enrollments / Please check one:*
☐ OPEN ENROLLMENT
☐ NEWLY ELIGIBLE
☐ NEW HIRE / DATE OF HIRE: ____ / ____ / ____

For Changes / Please check all that apply:
☐ PLAN CHANGE ☐ NAME CHANGE
☐ PHYSICIAN CHANGE ☐ ADDRESS CHANGE
☐ ADD DEPENDENT / QUALIFYING EVENT (birth, marriage, etc.) _____

Reason codes on reverse side:
☐ CANCEL POLICY / Reason code _____
☐ REMOVE DEPENDENT / Reason code _____
Dependent ID # _____

4. PLEASE PRINT AND RETURN TO YOUR EMPLOYER UPON COMPLETION. THANK YOU FOR CHOOSING INDEPENDENT HEALTH.

APPLICANT'S LAST NAME | FIRST NAME | MI

GENDER ☐ MALE ☐ FEMALE
EMPLOYEE STATUS ☐ ACTIVE ☐ RETIREE DATE ___/___/___
EMPLOYER

ADDRESS (NUMBER, STREET, APARTMENT)

WHAT IS YOUR PRIMARY LANGUAGE?

HAVE YOU EVER BEEN A MEMBER OF INDEPENDENT HEALTH?
☐ YES If yes, list your identification number
☐ NO

CITY | COUNTY | STATE | ZIP + 4

PRIOR HEALTH INSURANCE: Date(s) for which you had coverage during the 12 months prior to your effective date.
COVERAGE DATES FROM: _____ TO: _____ FROM: _____ TO: _____
(Please provide detail on the reverse side of this form)

TELEPHONE
HOME: ( ) - WORK: ( ) - EMAIL

WILL YOU CONTINUE THIS COVERAGE WHILE ENROLLED IN INDEPENDENT HEALTH? Yes ☐ No ☐

5. Member Information:

LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP
APPLICANT					SELF Code * ☐
SPOUSE					☐ HUSBAND ☐ WIFE Code * ☐
CHILD					☐ Daughter ☐ Son Code * ☐
CHILD					☐ Daughter ☐ Son Code * ☐
CHILD					☐ Daughter ☐ Son Code * ☐

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FOR INTERNAL USE ONLY
NETWORK _____
SUB NETWORK _____

* Please identify status code: A† - Adopted (within last 18 months) P† - Adoption in Process S - Stepchild H - Handicapped D - Disabled L - Legal Guardianship G - Grandchild † Please attach Adoption/Adoption in Process papers

6. While enrolled in Independent Health, will you or your dependent(s) be covered by any of the following: If additional space is required, please attach a separate sheet.

CHECK YES OR NO:
• MEDICARE ☐ Yes (Please list all covered members) ☐ No
• OTHER HEALTH INSURANCE* ☐ Yes (Please list all covered members) ☐ No
*Including no fault and/or workers' compensation (in the event of an injury).

LAST NAME | FIRST | MI
LAST NAME OF POLICY HOLDER | FIRST | MI

ID NO. _____
PART A EFF. DATE _____ PART B EFF. DATE _____
INSURANCE NAME
PHONE NO.

7. Is your child (or children) a full-time college student? ☐ Yes ☐ No
If yes, please complete section on back of application.

8. AUTHORIZATION: I have read and agree to the authorization on the reverse side of this form.

ALL SECTIONS MUST BE COMPLETED BEFORE PROCESSING.

SUBSCRIBER'S SIGNATURE: _____ DATE: _____

IH USE ONLY | Effective Date | Pre Ex | Group Number | Account Number | Tier Code | Benefit Package Code

REASON CODES:

- **B.** Dependent Reached Age 23/24/25
- **C.** Group Cancel - Open Enrollment
- **D.** Deceased
- **G.** Group Cancel - Mid-contract
- **I.** Transferring to Another Group
- **L.** Layoff
- **M.** Moved out of Area
- **N.** Nonpayment
- **O.** Member Cancel - Open Enrollment
- **P.** Personal Reasons
- **R.** Retired
- **T.** Terminated Employment
- **U.** Dependent Age Cut-off (age 19)
- **V.** Medicare
- **W.** Now Under Spouse's Plan
- **X.** No Longer Eligible
- **Y.** Dissatisfaction with the Plan
- **Z.** Dependent Age Cut-off - Waiver Required

ELIGIBILITY FOR STUDENT COVERAGE

(applies only to those members whose contract includes an age extension rider)

Your contract may require that a dependent age 19 or above maintain full-time student status (a minimum of 12 credit hours) at an accredited college or university to remain eligible as a dependent on your contract.

Please check the statement that best describes your child's student status:

☐ **Yes, my child is a full-time college student** as defined above.
Following is information that may be verified:

Child	College or University	Student ID No.
Address	City, State, Zip Code	Expected Date of Graduation
Child	College or University	Student ID No.
Address	City, State, Zip Code	Expected Date of Graduation

(Please attach separate sheet if you have additional children who are eligible full-time students)

☐ **Yes, my child is a full-time college student but is currently on medical leave.** Please attach a note from your physician verifying your child's condition.

☐ **No, my child is not a full-time college student.** Please send me information on a direct pay policy.

PRIOR HEALTH INSURANCE (CONTINUED)

HEALTH INSURANCE COMPANY (include address and phone number of previous carrier)	ID #	COVERAGE FROM MONTH/YEAR	COVERAGE TO MONTH/YEAR

CERTIFICATION & CONSENT

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. This application cannot be processed if birth date(s) and Social Security Number(s) are not completed. I understand that 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 be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

I understand that this application and my, 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 remitting claims payments to us.[1]

I consent to any person or institution who 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 us. Any information received or generated by us shall be kept confidential and secure as required by applicable law. I also consent to you disclosing my health information or the health information of any member of my family, as permitted by applicable law, for your own or another provider, health plan, health care clearinghouse or other covered entity's treatment, payment or health care operations. This consent shall remain in effect until revoked by me in writing.

I acknowledge that if I am presently without coverage for longer than sixty-three (63) days, then a pre-existing condition waiting period may apply. Pre-existing condition waiting periods apply to individuals with conditions diagnosed or recommended for treatment within six (6) months prior to the enrollment date of new coverage and shall not exceed twelve (12) months following this date.

[1] The terms "You" and/or "Us" means Independent Health Association, Inc. or Independent Health Benefits Corporation for members who enroll in a health coverage product through their employers or individually. For members whose employers self-insure their health coverage, the terms "You" and/or "Us" means Independent Health Corporation, a third-party administration company.