NY44 Health Benefits Plan Trust
An Erie 1 BOCES Initiative

Please choose one: ☐ **Administrator** ☐ **Teacher** ☐ **SRP** ☐ **Retiree**

1. Please check one: ☐ **Group Enrollment Application** ☐ **Change Form**

2. **Effective Date** ____/____/____ **Group #**_____ **Employer:**_____

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

For New Changes / Please check one:
- ☐ NAME CHANGE
- ☐ ADDRESS CHANGE
- ☐ ADD DEPENDENT/QUALIFYING EVENT (birth, marriage, etc.) *Provide appropriate documents. Refer to Sec. 3; 2c "Eligibility and Conditions of Coverage" of the Summary Plan Description.
- ☐ REMOVE DEPENDENT

4. **PLEASE PRINT AND RETURN TO YOUR EMPLOYER UPON COMPLETION.**

APPLICANT'S LAST NAME FIRST NAME MI

ADDRESS (NUMBER, STREET, APARTMENT)

CITY COUNTY STATE ZIP + 4

SOCIAL SECURITY NUMBER

TELEPHONE

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

GENDER
- ☐ FEMALE
- ☐ MALE

EMPLOYEE STATUS
- ☐ ACTIVE
- ☐ RETIREE DATE ___/___/___

HAVE YOU EVER BEEN A HEALTH BENEFITS PLAN TRUST MEMBER
- ☐ YES If yes, list your identification number
- ☐ NO

PRIOR HEALTH INSURANCE: New enrollees MUST submit a letter of Creditable Coverage with the application at the time of enrollment. Otherwise, your claims may be denied for pre-existing.

COMPANY NAME:_____

ADDRESS_____ PHONE NUMBER:_____

COVERAGE DATES FROM: _____ TO: _____ FROM: _____ TO: _____
Date(s) for which you had coverage the 12 months prior to your effective date.

ID#_____

WILL YOU CONTINUE THIS COVERAGE WHILE ENROLLED IN THE HEALTH BENEFITS PLAN TRUST? ☐ YES ☐ NO

5. **Member Information:**

LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY #	DATE OF BIRTH	RELATIONSHIP
APPLICANT					☐ SELF
SPOUSE					☐ SPOUSE ☐ DOMESTIC PARTNER
CHILD					☐ SON ☐ DAUGHTER ☐ SPECIAL NEEDS CHILD
CHILD					☐ SON ☐ DAUGHTER ☐ SPECIAL NEEDS CHILD
CHILD					☐ SON ☐ DAUGHTER ☐ SPECIAL NEEDS CHILD

6. **While enrolled in the Health Benefits Plan Trust, 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 CARE INSURANCE*
☐ YES **(Please list all covered members)**
☐ NO
*including no fault and/or workers' compensation (in the event of an injury)

APPLICANT'S LAST NAME FIRST NAME MI

LAST NAME OF **POLICY HOLDER** FIRST NAME MI

ID NO._____

PART A EFF. DATE_____ PART B EFF. DATE_____

INSURANCE NAME

PHONE NUMBER

7. Is your child (or children) between the ages of 19-26? ☐ YES ☐ NO
If yes, see requirements on back of application.

8. AUTHORIZATION: I have read and agree to the authorization (certification & consent) on the reverse side of this form.

SUBSCRIBER'S SIGNATURE:_____DATE:_____

ALL SECTIONS MUST BE COMPLETED BEFORE PROCESSING.

ELIGIBILITY FOR COVERAGE

The NY44 Health Benefits Plan Trust in compliance with the Patient Protection and Affordable Care Act of 2010 for Children of Enrollees between the ages 19-26 requires the following information including photocopies of Social Security card and birth certificate:

Name of Child: _____

Child's Permanent Residence Address Street, City, State, and Zip Code: _____

Child's Date of Birth: _____

I understand that my child's coverage with the NY44 Health Benefits Plan will end on the last day of the month in which he/she reaches his/her 26th birthday. I will notify my Benefit Administrator to end my child's coverage with the NY44 Health Benefits Plan at such time as he/she is eligible for health benefits coverage through his/her employer.

Signature of Enrollee:_____Date: _____

Office Use Only:
Photocopies received for: ☐ Social Security Card ☐ Birth Certificate

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) 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 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 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 my 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.

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[1] For members whose employers self-insure their health coverage, the terms "You" and/or "Us" means a third-party administration company (TPA).