Application for Individual Off-Exchange Direct Pay HMO

Instructions

- Please type or print firmly with ballpoint pen.
- This application may be used to apply for new enrollment, or to change your type of contract. Complete this application if you or your spouse, or both, are not eligible for Medicare due to age. Your contract should be appropriate (Individual, Family, Child Only, Self/Spouse & Self/Child) to your status as indicated below:

Individual

- If you are unmarried, widowed, divorced, or legally separated and have no dependent children.
- If you are married without dependent children, and each spouse would prefer their own individual contract.
- If your spouse is Medicare eligible, and/or you have dependents under the age of 26 and do not wish to purchase a policy that covers dependents.

Self/Spouse, Self/Child, and Family

- If you are married, or if you are married with dependent children. If you are married and your spouse is eligible for Medicare, and you're covering one or more dependents under age 26, you should apply for a desired contract for you and your child(ren). Your Medicare-eligible spouse should apply for separate coverage using a Non-Group Medicare Supplement Insurance Application Form.
- If you are unmarried, widowed, divorced, or legally separated and you're covering one or more dependent children.
- If you have one or more dependent children under 26 years of age, complete only one application for desired coverage for yourself and your children.

Child Only

- If you are purchasing coverage for a child only. This contract will not provide coverage for the Responsible Adult.
- If you are the Responsible Adult for a child under 21 years of age. Children covered under this contract include natural children, legally adopted children, step children, children for whom the Responsible Adult is the proposed adoptive parent, and children for whom the Responsible Adult is the legal guardian. Foster children and grandchildren of the Responsible Adult are not covered.
- If you would like to purchase a Child Only contract for more than one child, please complete a separate application for each additional child.
- When submitting your completed application, you must include a check or money order.
- All applicants must:
 - 1. Complete, sign, and date the application where indicated.
 - 2. Check the appropriate boxes for type of coverage and type of contract.
 - 3. Return the completed application with a check or money order to:

EmblemHealth ATTN: IND DM Sales Direct Pay 55 Water Street, 8th Floor New York, NY 10041-8190

Payable Amount \$	Check No.	Money Order No.
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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 five thousand dollars and the stated value of the claim for each such violation.

EmblemHealth individual payment plans are underwritten by Health Insurance Plan of Greater New York (HIP).

EmblemHealth Plan, Inc., EmblemHealth Insurance Company, EmblemHealth Services Company, LLC and Health Insurance Plan of Greater New York (HIP) are EmblemHealth companies. EmblemHealth Services Company, LLC provides administrative services to the EmblemHealth companies.

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	t: □ Individual Requested Plan st		•	_ P	arent & Child(ren)) ∐ F	amily	(Individual/Spouse & Cl	nild(rer	n) □ Child Only
Please specify P	lan:									
Plans listed belo Select Care F Select Care C Select Care S	Gold D □ Sele	ect Care B			Plans listed belo Millennium P Millennium G Millennium S	latinuı old D	m D	of our Millennium Netwo Millennium Bronze Millennium Catastr	D)
• All enrollees/r		g enrollme	ent after the er	nd c	of Open Enrollmer	nt mus	st have	e a qualifying life event	in orde	r to be eligible for
• Please check h	nere if you are you a	applying a	fter the end of	Ор	en Enrollment wi	th a qı	ualifyi	ng life event. \square		
	n option for yourself and a be at least 16 years old in					e Regist	ry for o	rgan, eye, and tissue donation		
 Please compl 	ete the following	informati	on for the sub	sc	riber.					
Subscriber's Last N	ame		First Name			M.I.		Date of Birth (MM/DD/YY)	Soc	cial Security Number
Birth Sex: What sex	were you assigned at b	irth?								
☐ Male	☐ Female	☐ Gender X			Unknown					
☐ Male	nat is your current gend Female r X, Genderqueer, or third your pronouns?	☐ Transger	der male/female-to ☐ Other: Prefer					☐ Transgender female/ male ☐ Choose not to disclose	-to-femal	e (MTF)
☐ He/him	☐ She/her	☐ They/the	m		Choose not to disclose					
Accessible format:										
☐ Not Applicable Sexual Identity: Wh	ich of the following bes	☐ B-Braille t describes v	mi?		L -Large Print			☐ A-Audio CD	☐ Choo	se not to disclose
☐ Straight or heterosexual ☐ Choose not to disc	☐ Lesbian or gay	☐ Bisexual			Queer, pansexual, and/ questioning	'or		☐ Don't know		r option not specified ething else)
☐ No, not of Hispanic Spanish origin ☐ Yes, Cuban		☐ Yes, Puer			Yes, Dominican			☐ Yes, Mexican, Mexican American Chicano/a		Some Other Hispanic, o/a, or Spanish Origin
☐ Black or African	☐ White	☐ Asian Inc	ian		American Indian or Ala	ska Nati	ive	☐ Native Hawaiian	☐ Chine	ese
American □ Filipino □ Guamanian or Chamorro	☐ Japanese ☐ Other Pacific Islander	African	astern or North		Vietnamese Two or more races			☐ Other Asian ☐ Some other race	□ Samo	oan se not to disclose
	our preferred language		Cantanasa		Chinasa Mandavin			□ Dussian	□ E***	ob Crools (Haitian Crools)
☐ English ☐ Bengali ☐ Polish ☐ Portuguese	□ Spanish □ Yiddish □ Tagalog □ Hindi	☐ Chinese, ☐ French ☐ Greek ☐ Americar	Sign Language		Chinese, Mandarin Italian Albanian Other Language			☐ Russian ☐ Korean ☐ Urdu ☐ Choose not to disclose	□ Frend □ Arab □ Vietr	
Home Address (P.O	. Box is not acceptable	2)			Telephone Number	S				
					Cell:		Home:	Work:		
City					County			State	ZIP	Code
Mailing Address (If	different from Home A	ddress)						[†] Donate Life Registry Yes	s Skip	o for now
City					County			State	ZIP	Code
Applicant Email Ad	dress				<u> </u>	PO	CP Nan	ne/ID Number		Go Paperless" (see below)

By electing "Go paperless," you will receive claim statements and some other EmblemHealth letters by email instead of paper mail. You will be able to view your Explanation of Benefits (EOBs) under the Claims portal of the EmblemHealth Website. Your enrollment in the "Go Paperless" option will continue as long as your account remains active, or until you choose to discontinue this option.

By completing this form, I consent to receive calls from a representative about EmblemHealth products and services at the number I have provided (including mobile devices). These calls may be made using an automated technology and my consent to receive these calls is not required as a condition for me to make a purchase.

Disclosure of race, ethnicity, language, sexual orientation or gender identity will not impact underwriting, denial of services, coverage and benefits, or be disclosed to unauthorized users.

Personal preferences may be updated within the Member Portal, once an account is created.

2. Please complete the following spouse and/or dependent child(ren) information if applying for a Family Contract. A dependent child will be covered until the end of the month in which he/she becomes 26 years of age.								
Spouse/Dependent's Last Name	First Name		M.I.	Date of Bi	rth (MM/DD/YY)	Relationship	Telephone (Daytime)	
Mailing Address (If different from above)		-	Email Add				
Social Security Number		PCP Name/ID Numb			[†] Donate Life Regist	Skip for now		
Birth Sex: What sex were you assigned at	birth?	1		I				
☐ Male ☐ Female	☐ Gender X	☐ Unkr	nown					
Gender Identity: What is your current ger							. (
☐ Male ☐ Female ☐ Non-binary, Gender X, Genderqueer, or thi Pronouns: What are your pronouns?	☐ Transgender male/feird gender ☐ Other:	emale-to-male (F Prefer to self-de:			☐ Choose not		to-female (MTF)	
☐ He/him ☐ She/her Accessible format:	☐ They/them	☐ Choo	se not to disclo	se				
☐ Not Applicable Sexual Identity: Which of the following be	☐ B-Braille est describes you?	□ L -La	rge Print		☐ A-Audio CD		☐ Choose not to disclose	
☐ Straight or ☐ Lesbian or gay heterosexual ☐ Choose not to disclose	□ Bisexual	-	er, pansexual, a tioning	nd/or	□ Don't know		☐ Other option not specified (something else)	
Ethnicity: Are you of Hispanic, Latino/a o	r Spanish Origin?							
□ No, not of Hispanic, Latino/a, or Spanish origin □ Yes, Cuban	☐ Yes, Puerto Rican ☐ Choose not to disclos		Dominican		☐ Yes, Mexica American C		☐ Yes, Some Other Hispanic, Latino/a, or Spanish Origin	
Race: Which category best describes you	r race?							
☐ Black or African ☐ White American	☐ Asian Indian		rican Indian or a	Alaska Native			☐ Chinese	
☐ Filipino ☐ Japanese ☐ Guamanian or ☐ Other Pacific Chamorro Islander	☐ Korean ☐ Middle Eastern or No African	☐ Vietr orth ☐ Two	or more races		□ Other Asiar □ Some other		☐ Samoan ☐ Choose not to disclose	
Language: What is your preferred language								
☐ English ☐ Spanish ☐ Bengali ☐ Yiddish ☐ Polish ☐ Tagalog ☐ Portuguese ☐ Hindi	☐ Chinese, Cantonese ☐ French ☐ Greek ☐ American Sign Langu	□ Italia □ Albai	☐ Chinese, Mandarin☐ Italian☐ Albanian☐ Other Language		☐ Russian☐ Korean☐ Urdu☐ Choose not	to disclose	☐ French Creole (Haitian Creole)☐ Arabic☐ Vietnamese	
Dependent's Last Name First Name		Jage 🗖 Othe			th (MM/DD/YY) Relationsh		Telephone (Daytime)	
Mailing Address (If different from above)			Email Add	dress			
Social Security Number		PCP Name/II) Number		†Donate Life Regist	try Yes 🗆	Skip for now	
Birth Sex: What sex were you assigned at		Unkr						
☐ Male ☐ Female Gender Identity: What is your current ger	☐ Gender X Ider identity:	⊔ Unkr	iown					
☐ Male ☐ Female ☐ Non-binary, Gender X, Genderqueer, or the Pronouns: What are your pronouns?	☐ Transgender male/fe ird gender ☐ Other:	male-to-male (F Prefer to self-de			☐ Transgende☐ Choose not		to-female (MTF)	
☐ He/him ☐ She/her Accessible format:	☐ They/them	☐ Choo	se not to disclo	ose				
☐ Not Applicable Sexual Identity: Which of the following be	☐ B-Braille	□ L -La	rge Print		☐ A-Audio CD		☐ Choose not to disclose	
☐ Straight or ☐ Lesbian or gay heterosexual ☐ Choose not to disclose	□ Bisexual	-	er, pansexual, a tioning	nd/or	□ Don't know		☐ Other option not specified (something else)	
Ethnicity: Are you of Hispanic, Latino/a o	r Spanish Origin?							
□ No, not of Hispanic, Latino/a, or Spanish origin □ Yes, Cuban	☐ Yes, Puerto Rican ☐ Choose not to disclos	•	Dominican		☐ Yes, Mexica American C		☐ Yes, Some Other Hispanic, Latino/a, or Spanish Origin	
Race: Which category best describes you								
☐ Black or African ☐ White	☐ Asian Indian	☐ Ame	rican Indian or a	Alaska Native	☐ Native Haw	aiian	☐ Chinese	
American Filipino Japanese Guamanian or Other Pacific Chamorro Islander	☐ Korean ☐ Middle Eastern or No African	□ Vietr orth □ Two	namese or more races		☐ Other Asiar☐ Some other		☐ Samoan ☐ Choose not to disclose	
Language: What is your preferred langua								
☐ English ☐ Spanish ☐ Bengali ☐ Yiddish ☐ Polish ☐ Tagalog ☐ Portuguese ☐ Hindi	☐ Chinese, Cantonese ☐ French ☐ Greek ☐ American Sign Langu	□ Italia □ Albai			□ Russian □ Korean □ Urdu □ Choose not	to disclose	☐ French Creole (Haitian Creole) ☐ Arabic ☐ Vietnamese	

3. The Responsible Adult must complete the following child only information if applying for a Child Only Contract . A child will be covered until the end of the year in which he/she becomes 21 years of age.									
Dependent 1 Last N	lame	First Name	-	M.I.	Date of Birth (MM/DD/YY)	Relationship		Telephone (Daytime)
Mailing Address (If	different from above)					Email Address			
Sex (M/F/Non-Binary) Social Security Number PCP Name/ID Number *Donate Life								□Skip	o for now
Birth Sex: What sex	were you assigned at l	birth?							
☐ Male	☐ Female	☐ Gender X	☐ Unki	nown					
-	nat is your current gend	-	/C / / / / / / / / / / / / / / / / / /	· T. 4\			C 1 / 1		(MTE)
☐ Male ☐ Non-binary, Gende Pronouns: What are	☐ Female er X, Genderqueer, or thire e your pronouns?	☐ Transgender male d gender ☐ Oth	r: Prefer to self-de			☐ Choose not	er female/ male- to disclose	-to-rema	le (MTF)
☐ He/him ☐ She/her ☐ They/them ☐ Choose not to disclose Accessible format:									
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☐ Straight or heterosexual ☐ Choose not to disc	☐ Lesbian or gay	☐ Bisexual	-	er, pansexual, ar stioning	nd/or	□ Don't know			er option not specified nething else)
	of Hispanic, Latino/a or	Spanish Origin?							
☐ No, not of Hispanio Spanish origin	c, Latino/a, or	☐ Yes, Puerto Rican		Dominican		☐ Yes, Mexica American C	*		, Some Other Hispanic, no/a, or Spanish Origin
☐ Yes, Cuban	ry best describes your	☐ Choose not to disc	close						
☐ Black or African American	□ White	☐ Asian Indian	☐ Ame	rican Indian or A	Alaska Native	☐ Native Haw	vaiian	☐ Chir	nese
Filipino Guamanian or	☐ Japanese ☐ Other Pacific	☐ Korean ☐ Middle Eastern or	☐ Vieto North ☐ Two	namese or more races		☐ Other Asian☐ Some other race		□ Sam	noan ose not to disclose
Chamorro	Islander	African							
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☐ Portuguese	☐ Hindi	☐ American Sign Lar	nguage 🔲 Othe	er Language		☐ Choose not	to disclose		
Dependent 2 Last N	Name	First Name		M.I.	Date of Birth (MM/DD/YY)	Relationship		Telephone (Daytime)
Mailing Address (If	different from above)					Email Address	S		
Sex (M/F/Non-Bina	ry) Social Security	y Number	PCP Name/IE) Number		†Donate Life R	egistry 🗌 Yes	□Skip	o for now
Birth Sex: What sex	were you assigned at l	birth?	'						
☐ Male Gender Identity: Wh	☐ Female nat is your current gend	☐ Gender X der identity:	□ Unkı	nown					
☐ Male ☐ Non-binary, Gende Pronouns: What are	☐ Female er X, Genderqueer, or thir	☐ Transgender male d gender ☐ Oth	/female-to-male (F er: Prefer to self-de			☐ Transgende☐ Choose not	er female/ male- to disclose	-to-fema	le (MTF)
☐ He/him Accessible format:	□ She/her	☐ They/them	☐ Choo	ose not to disclo	se				
☐ Not Applicable	ich of the following bes	☐ B-Braille	□ L -La	arge Print		☐ A-Audio CD)	□ Cho	ose not to disclose
☐ Straight or heterosexual	☐ Lesbian or gay	☐ Bisexual	-	er, pansexual, ar stioning	nd/or	□ Don't know			er option not specified nething else)
Choose not to disc	close of Hispanic, Latino/a or	Snanish Origin?							
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☐ Yes, Cuban		☐ Choose not to disc	close				-,		, , , , , , , , , , , , , , , , , , , ,
☐ Black or African	ry best describes your ☐ White	race?	☐ Ame	rican Indian or A	Alaska Native	☐ Native Haw	raiian	☐ Chir	nese
American □ Filipino □ Guamanian or	☐ Japanese☐ Other Pacific	☐ Korean ☐ Middle Eastern or		namese or more races		☐ Other Asiar☐ Some other		□ Sam	noan ose not to disclose
Chamorro	Islander	African							
	our preferred language		n	oco Mandaria		□ Duosio =		□ □ □ □	och Croole (Heitier Crools)
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☐ Portuguese	☐ Hindi	☐ American Sign Lar	nguage 🗆 Othe	er Language		☐ Choose not	to disclose		

Dependent 5 Las	t Name	F	irst Name		M.I.	Date of Birth (MM/DD/YY)		Relationship		T	elephone (Daytime)
Mailing Address	(If different from above))					Email Address	3			
Sex (M/F/Non-Bir	nary) Social Securit	y Number	-	PCP Name/ID	Number		[†] Donate Life Ro	egistry	☐ Yes ☐ S	kip fo	or now
Birth Sex: What s	ex were you assigned at	birth?				·					
☐ Male Gender Identity: \(\)	☐ Female What is your current gen	☐ Gend der identit		☐ Unkn	own						
☐ Male ☐ Female ☐ Transgender male/female-to-male (FTM) ☐ Non-binary, Gender X, Genderqueer, or third gender ☐ Other: Prefer to self-describe Pronouns: What are your pronouns?							☐ Transgende☐ Choose not			nale ((MTF)
☐ He/him Accessible forma	☐ She/her	☐ They,	/them	☐ Choo	se not to disclos	e					
☐ Not Applicable		☐ B-Bra		☐ L -Laı	ge Print	Print)	□с	hoose	e not to disclose
Sexual Identity: V	Vhich of the following be	st describ	es you?								
☐ Straight or heterosexual ☐ Choose not to d	☐ Lesbian or gay isclose	☐ Bisex	ual	-	Queer, pansexual, and/or questioning		□ Don't know				option not specified hing else)
	ı of Hispanic, Latino/a o	•	•								
☐ No, not of Hispa Spanish origin ☐ Yes, Cuban	nic, Latino/a, or	,	Puerto Rican se not to disclos	ŕ	Dominican		☐ Yes, Mexica American C	-			ome Other Hispanic, a, or Spanish Origin
	gory best describes your		sc not to disclos								
☐ Black or African American	☐ White	☐ Asian	Indian	☐ Amer	ican Indian or A	laska Native	☐ Native Hawaiian		□С	hines	е
☐ Filipino ☐ Guamanian or Chamorro	☐ Japanese ☐ Other Pacific Islander	☐ Korea ☐ Middl Africa	le Eastern or No	☐ Vietn rth ☐ Two o	amese or more races					☐ Samoan ☐ Choose not to disclose	
	s your preferred languag		ill								
☐ English ☐ Bengali ☐ Polish ☐ Portuguese	☐ Spanish ☐ Yiddish ☐ Tagalog ☐ Hindi	☐ Chine ☐ Frenc ☐ Greek		□ Italiaı □ Albar	☐ Chinese, Mandarin☐ Italian☐ Albanian☐ Other Language		☐ Korean		□ A □ V	☐ French Creole (Haitian Creole) ☐ Arabic ☐ Vietnamese	
4. Please prov	vide the following i	nformat	ion for vou	r current or	prior healt	h benefits r	olan (if anv)				
	e and Address		Telephone N		Name of		Policy I.D.		Effective Da	ate	Termination Date
71	surer		of Insurer		Policyholder		Number		of Prior Pol		of Prior Policy
Hospital			()								
			,								
Medical			()								
Medical 5. Medicare E	ligibility		()								
5. Medicare E	ligibility ying for individual c	overage,	and if your	spouse is eli	gible for Me	dicare, chec	k here				
5. Medicare E	ying for individual c	overage,	and if your	spouse is eli	gible for Me	dicare, chec	k here				
5. Medicare E If you are appl 6. Age 29 Cov The Age 29 Ric	ying for individual c	ndent ch	ild coverage	e to the end	of the montl	n he/she bec	omes 30 yea		age and is 9 Rider [lable for purchase.
5. Medicare E If you are appl 6. Age 29 Cov The Age 29 Ric	ying for individual cerage der will extend depende box if the dependent	ndent ch	ild coverage	e to the end	of the montl	n he/she bec	omes 30 yea		_		lable for purchase.
5. Medicare E If you are appl 6. Age 29 Cov The Age 29 Ric Please check t 7. Change in Co If you are pre	ying for individual cerage der will extend depende box if the dependent	ndent chil	ild coverage d(ren) requi	e to the end o	of the montl ase of the A	n he/she bec ge 29 Rider.	omes 30 yea Purchase	Age 2	9 Rider [
5. Medicare E If you are appl 6. Age 29 Cov The Age 29 Ric Please check t 7. Change in Co If you are pre status, please	ying for individual cerage der will extend dependent box if the dependence certage sently enrolled und	ndent childent childe	ild coverage d(ren) requi nblemHealt x below.	e to the end ore the purch	of the montl ase of the A ment Hosp	n he/she bec ge 29 Rider. ital/Medica	omes 30 yea Purchase	Age 2	9 Rider [
5. Medicare E If you are appl 6. Age 29 Cov The Age 29 Ric Please check t 7. Change in Co If you are pre status, please	ying for individual cerage der will extend dependent the box if the dependence sently enrolled under the check the appropriate the second the s	ndent childent child	ild coverage d(ren) requi	e to the end ore the purch	of the montl ase of the A ment Hosp	n he/she bec ge 29 Rider. ital/Medica	omes 30 yea Purchase	Age 2	9 Rider [

If I have selected to purchase the Age 29 Rider I have included those dependent children under 29 years of age. I make this application on their behalf as well as my own.

When the application is processed, coverage will be effective only if payment is received in accordance with the invoice. I represent and understand that:

- A. On my enrollment date, my existing contract(s), if any, will be canceled.
- B. All statements and answers in this application are true to the best of my knowledge and belief.

NOTE: BEFORE DATING AND SIGNING THIS APPLICATION, PLEASE MAKE SURE YOU HAVE ANSWERED ALL THE QUESTIONS, AND HAVE CHECKED THE APPROPRIATE BOX FOR TYPE OF COVERAGE YOU DESIRE.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim concerning any materially false information, or conceals for the purposes 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 five thousand dollars and the stated value of the claim for each such violation.

Applicant's Signature (Do Not Print)		Date Signed
Applicant's Spouse's Signature (Do Not Print)	Necessary Only When Applying For Family Coverage	Date Signed
Responsible Adult's Signature (Do Not Print)	Necessary Only When Applying For Child Only Coverage	Date Signed

EmblemHealth Website

Once coverage is effective, members have fast, convenient access to the latest claim status, eligibility, rate information, and benefits information, visit EmblemHealth's secure member website at emblemhealth.com. Available around the clock, the site offers provider listings, enables you to order ID cards, view an online Explanation of Benefits, access wellness information, and much more.

EmblemHealth Customer Service

Language assistance services, free of charge, are available to you. Call 877-411-3625 (TTY: 711).

Select Care Network

The EmblemHealth Select Care Network is a competitive, mid-tier network servicing members in 19 New York counties, consisting of Delaware, Dutchess, Orange, Putnam, Sullivan, Ulster, Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington, Broome, and Otsego.

Millennium Network

The EmblemHealth Millennium Network is our most affordable network giving members in the 5 boroughs, Rockland, Nassau County, Suffolk County, and Westchester County access to top providers and hospitals in the region.

Broker Commissions

Premium for all individual Qualified Health Plan policies includes the cost of using a licensed insurance broker to assist individuals in selecting a plan. Insurance brokers are paid a fee of \$15 per contract per month.

For EmblemHealth Office Use Only							
	(Initials)	(Initials)					
Date Application Issued							
Date Application Received							
Date Application Processed							
Date, Contract and Copy of Application Sent							
Type of Plan							
Group Number							
Benefit Set ID							
Effective Date							
Rep ID							