

# **Transaction Form for Group Accounts**

I. SUBSCRIBER IN	FORMATION											
Last Name			First Nam	ne			1	M.I.	Social Sec	urity Nu	ımber	
Street Address		Apt.	Apt. City					State			ZIP Code	
Were you ever a me If YES, member ID	mber of EmblemHealth	?  \[ \text{NO } \[ \text{YES} \]	Marital S ☐ Single	Marital Status:  ☐ Single ☐ Married ☐ Domestic Partner			Birth Da			<b>e:</b> Mo./D	ay/Yr.	
Birth Sex: What sex	Birth Sex: What sex were you assigned at birth?											
☐ Male	☐ Female	☐ Gender X		☐ Unknov	vn							
Gender Identity: WI	hat is your current geno	der identity:										
☐ Male ☐ Female ☐ Transgender mal			r male/female-	lle/female-to-male (FTM)			□ Transgender female/ male-to-female (MTF)					
☐ Non-binary, Gend	er X, Genderqueer, or thi	ird gender 🗆 🗆	Other: Prefer	her: Prefer to self-describe				oose not to disclose				
Pronouns: What are	your pronouns?											
☐ He/him	☐ She/her ☐ They/them			☐ Choose not to disclose								
Accessible format:												
☐ Not Applicable		☐ B-Braille		☐ L -Large Print ☐ A-Audio			☐ A-Audio (	CD Choose not to disclose			: to disclose	
Sexual Identity: Wh	ich of the following bes	st describes you	?									
☐ Straight or heterosexual	□ Lesbian or gay	□ Bisexual		□ Queer, questio	pansexual, and/o	or [	□ Don't kno	OW			ner option not specified mething else)	
☐ Choose not to dis												
	of Hispanic, Latino/a or											
☐ No, not of Hispanic, Latino/a, or ☐ Yes, Puerto Rica Spanish origin						□ Yes, Mexi American	ican, Mexican Yes, Some Other Hispanic, Chicano/a Latino/a, or Spanish Origin					
☐ Yes, Cuban		☐ Choose not	to disclose									
Race: Which category best describes your race?												
☐ Black or African American	☐ White	☐ Asian Indian		☐ Americ Native	an Indian or Alas			awaiia				
☐ Filipino	☐ Japanese	☐ Korean		□ Vietnar	☐ Vietnamese		□ Other Asi	ian		□ San		
Chamorro	☐ Guamanian or ☐ Other Pacific ☐ Middle Eastern or North Chamorro ☐ Islander ☐ African			☐ Two or more races ☐ Some other			ier ra	r race				
Language: What is y	your preferred language	e?										
☐ English	☐ Spanish ☐ Chinese, Cantonese		☐ Chinese, Mandarin			☐ Russian					ole (Haitian Creole)	
□ Bengali	☐ Yiddish	☐ French		☐ Italian			☐ Korean			☐ Arabic		
☐ Polish	☐ Tagalog	☐ Greek		☐ Albanian ☐ Urdu				☐ Vietnamese			е	
☐ Portuguese	☐ Hindi	☐ American Si		□ Other L			☐ Choose n	ot to	disclose			
Applicant's hours wor	rked per week: At leas				RA Retiree (s	ee back o	of form**)		-			
Type of Coverage:       ☐ Individual       ☐ Family       ☐ Employee 8         Email Address:			Employee & S <sub>l</sub>	ouse/DP				Work Tel. #:  Cell Tel. # (see back of form*):				
Note: If electing Young Adult Coverage, please submit a completed Yo				ung Adult Election Form					Go Paperless" (see back of form)***			
Primary Care Physician Name: (Not required for EPO/PPO mem							ID Number:					
		·	-									
OB/GYN Selection Name: (Optional)									ID Number	r:		
Are you covered by a	Are you covered by any other health insurance or Medicare? NO YES If YES, indicate. Check One: Status: Transfer:											
Insurance Co. Name:  New Enrollment Add Dependent To Another Carrier Reinstatement Remove Dep. EmblemHealth Group							blemHealth Group					
Insurance Co. Telephone #: Type of Coverage			age:		☐ Termination☐ Change			☐ Address Change ☐ Name Change			ange: m:	
Policy #:	Dlicy #: Effective Date:					2			_	To:		

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II. ENROLLMENT INFORMATION — IF YOU ARE ENROLLING YOUR SPOUSE/DP AND/OR CHILDREN, PLEASE LIST EACH ONE BELOW — SEE ELECTION OF COVERAGE FOR ELIGIBILITY										
<b>Note:</b> A birth/marriage certificate or 1040 Form will be required for spouse/dependents with different last name.										
Spouse/Dependent										
Dependent Last Name (if different)			First Name				M.I. Social Security Number			
*Donate Life Registry Yes Skip for now				Relationship Spouse DP Child			Birth	Date: Mo	/Day/Yr.	√ if Disabled¹
Primary Care Physician Name/ID Number (Not required for EPO/				bers)	OB/GYN Select	tion Name/ID N	Numbe	r (Optiona	1)	
Birth Sex: What sex v	vere you assigned at b	irth?								
☐ Male	☐ Female	☐ Gender X		☐ Unknown						
Gender Identity: Wha	it is your current gend	ler identity:								
☐ Male ☐ Female ☐ Transgender ma ☐ Non-binary, Gender X, Genderqueer, or third gender ☐ Or Pronouns: What are your pronouns?				-to-male (FTM) er to self-describ	e	□ Transgend □ Choose no			-to-female (MTF)	
☐ He/him	☐ She/her	☐ They/them		☐ Choose not	to disclose					
Accessible format										
☐ Not Applicable		☐ B-Braille		□ L -Large Pri	nt	☐ A-Audio C	CD			se
Sexual Identity: Which	ch of the following bes	t describes you?								
☐ Straight or heterosexual ☐ Choose not to discl Ethnicity	heterosexual Choose not to disclose			□ Queer, pans questioning		□ Don't kno	w □ Other option not spec (something else)		ecified	
☐ No, not of Hispanic, Latino/a, ☐ Yes, Puerto Rican or Spanish origin ☐ Yes, Cuban ☐ Choose not to disc			•		☐ Yes, Mexican, Mexican American Chicano/a		☐ Yes, Some Other Hispanic, Latino/a, or Spanish Origin			
	y best describes your		sciose							
☐ Black or African American	☐ White	☐ Asian Indian		☐ American Indian or Alaska Native		☐ Native Hawaiian			☐ Chinese	
☐ Filipino ☐ Guamanian or Chamorro	☐ Japanese ☐ Other Pacific Islander	□ Korean □ Middle Eastern or North African		☐ Vietnamese ☐ Two or more races		☐ Other Asian ☐ Some other race			□ Samoan □ Choose not to disclose	
	our preferred language			□ Ohimana Ma		☐ Russian			☐ French Creole (Haitia	(
☐ English☐ Bengali☐ Polish☐ Portuguese	☐ Spanish ☐ Yiddish ☐ Tagalog ☐ Hindi	☐ Chinese, Cantonese ☐ French ☐ Greek ☐ American Sign Languag		☐ Chinese, Mandarin ☐ Italian ☐ Albanian ☐ Other Language		☐ Korean ☐ Urdu ☐ Choose not to disclose		sclose	☐ Arabic☐ Vietnamese	
Current Health Insuran	ce Information:									
Carrier Name: Coverage Begin Date: Coverage End Date:										
Dependent										
Dependent Last Name (if different)			First Name				M.I. Social Security Number			
<sup>†</sup> Donate Life Registry	☐ Yes ☐ Skip for now		Relation	<b>1ship</b> $\square$ Spouse	☐ DP ☐ Child		Birth	Date: Mo	/Day/Yr.	√ if Disabled¹
Primary Care Physician Name/ID Number (Not required for EPO/PPO members)  OB/GYN Selection Name/ID Number (Optional)										
Birth Sex: What sex v	vere you assigned at b	pirth?								
☐ Male	☐ Female	☐ Gender X		□ Unknown						
	nt is your current gend									
☐ 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?					e	☐ Transgend☐ Choose no			-to-female (MTF)	
☐ He/him  Accessible format	☐ She/her	☐ They/them	☐ Choose		to disclose					
□ Not Applicable		☐ B-Braille		☐ L -Large Pri	☐ L -Large Print ☐ A-Audio C			CD Choose not to disclose		
	h of the following has					_ // // // // /	-		55500 Hot to distil	
Sexual Identity: Which of the following best describes you?  Straight or Lesbian or gay Bisexual heterosexual Choose not to disclose			☐ Queer, pans questioning		□ Don't kno	☐ Don't know ☐ Other option not spec (something else)			ecified	

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Ethnicity										
<ul><li>☐ No, not of Hispanic or Spanish origin</li><li>☐ Yes, Cuban</li></ul>	Yes, Cuban ☐ Choose not to dis			☐ Yes, Dominican		☐ Yes, Mexican, Mexican American Chicano/a			☐ Yes, Some Other Hispanic, Latino/a, or Spanish Origin	
Race: Which category	y best describes your	race?								
☐ Black or African	☐ White	☐ Asian Indian		☐ American Indian or		☐ Native Ha	awaiiar	1	☐ Chinese	
American □ Filipino	☐ Japanese	☐ Korean		Alaska Native □ Vietnamese		☐ Other Asi	an		☐ Samoan	
☐ Guamanian or	☐ Other Pacific	☐ Middle Eastern or		☐ Two or more races		☐ Some oth		е	☐ Choose not to disclose	
Chamorro	Islander	North African								
	our preferred language									
□ English □ Bengali	☐ Spanish ☐ Yiddish	☐ Chinese, Canton ☐ French	ese	☐ Chinese, Mandarin ☐ Italian		□ Russian □ Korean			☐ French Creole (Haitian Creole) ☐ Arabic	
☐ Polish	☐ Tagalog	☐ Greek		☐ Albanian		□ Urdu			☐ Vietnamese	
☐ Portuguese	☐ Hindi	☐ American Sign L	anguage	☐ Other Langu	uage	☐ Choose n	ot to d	isclose		
Current Health Insuran Carrier Name:	ce Information:	Coverage Begin Da	ate:		Coverage En	d Date:			_	
Dependent 2										
Dependent Last Name	(if different)		First Na	ma			LMI	Coolel C	Pagurity Number	
Dependent Last Name	(ii dillerent)		FIISL INdi	ne			M.I.	Social S	Security Number	
<sup>†</sup> Donate Life Registry	☐ Yes ☐ Skip for now		Relatio	nship 🗆 Spouse	□DP□Child		Birth	<b>Date:</b> Mo	o./Day/Yr.	√ if Disabled¹
Primary Care Physici	an Name/ID Number (	Not required for EPO/	PPO mem	bers)	OB/GYN Select	ion Name/ID I	Numbe	er (Optiona	al)	J.
Birth Sex: What sex v	vere you assigned at b	oirth?								
☐ Male	☐ Female	☐ Gender X		☐ Unknown						
Gender Identity: Wha	ıt is your current geno	ler identity:								
☐ Male	☐ Female	☐ Transgender ma	le/female	-to-male (FTM)		☐ Transgen	der fer	nale/ mal	e-to-female (MTF)	
☐ Non-binary, Gender X, Genderqueer, or third gender ☐ Other Pronouns: What are your pronouns?			ther: Prefe	er to self-describ	e	☐ Choose n	ot to d	isclose		
☐ He/him										
Accessible format										
□ Not Applicable □ B-Braille				☐ L -Large Pri	nt	☐ A-Audio (	CD		☐ Choose not to disclose	!
Sexual Identity: Which	ch of the following bes	st describes you?								
☐ Straight or ☐ Lesbian or gay ☐ Bisexual				☐ Queer, pans		☐ Don't kno	w		☐ Other option not speci	fied
heterosexual questioning (something else)  ☐ Choose not to disclose										
Ethnicity										
□ No, not of Hispanic, Latino/a, □ Yes, Puert			n	☐ Yes, Domini	ican	☐ Yes, Mexi			☐ Yes, Some Other Hispa	,
or Spanish origin  ☐ Yes. Cuban ☐ Choose not t			isclose		American Chicano/a			Latino/a, or Spanish Origin		
,	y best describes your		301030							
☐ Black or African ☐ White ☐ Asian Indian				☐ American In		☐ Native Ha	waiiar	1	☐ Chinese	
American ☐ Filipino ☐ Japanese ☐ Korean				Alaska Nati	☐ Other Asian			□ Samoan		
☐ Guamanian or ☐ Other Pacific ☐ Middle Eastern o			or	☐ Two or mor	☐ Some oth		9	☐ Choose not to disclose		
Chamorro	Islander	North African								
	our preferred language			□ Chinasa Ma	un ala uin	□ Dussian			□ Eveneh Cveele (Heitien	Cuanta
□ English □ Spanish □ Chinese, Cantonese □ Bengali □ Yiddish □ French			□ Chinese, Mandarin □ Italian		□ Russian □ Korean			☐ French Creole (Haitian Creole) ☐ Arabic		
□ Polish	☐ Tagalog	☐ Greek		☐ Albanian		Urdu			☐ Vietnamese	
☐ Portuguese	☐ Hindi ☐ American Sign Language ☐ Other Language ☐ Choose not to disclose									
Current Health Insurance Information:										
Carrier Name:	Carrier Name: Coverage Begin Date: Coverage End Date:									
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 requ	uired to process this fo	orm. Your signature a	attests th	at you have read	the reverse sid	e of this form.				
false information, or c	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.									
Applicant must sign h	nere:						_ Da	te:		

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III. EMPLOYER INFORMATION — THIS SECTION TO BE COMPLETED BY EMPLOYER/CONTRACTOR GROUP							
Name of Group:	Group Number:	Sub Group ID Class ID	Plan ID				
	If you selected a small group metal plan, please indicate which plan you are selecting :						
Health Insurance Plan of Greater New York (HIP) EmblemHealth Plan, Inc. EmblemHealth Insurance Company Plan Name:							
Requested Effective Date: Medical: Dental: Hire Date: Waiting Period: Date Submitted:							
Approved By: (Group Plan Administrator)							
Instructions to Benefit Administrators or Group Representatives: For grouthis form. Required documentation MUST be attached to this Transaction		nt eligible employees, you MUST co	mplete Section A on the reverse side of				

### IMPORTANT INFORMATION

- 1. The subscriber must complete sections I and II. The group plan administrator must complete section III, and if for a small group (100 or fewer full-time equivalent eligible employees) provide all necessary documentation.
- 2. All transactions are subject to EmblemHealth's retroactive enrollment period members must be enrolled within 30 days (for small groups) or 90 days (for large groups) from the Qualifying Event.
- 3. As part of New York State's "Age 29" law, eligible young adults through age 29 may obtain coverage through a parent's group policy.
- 4. Failure to complete any part of this form (e.g., group number, reason for submission, certificate number, signature, etc.) will require EmblemHealth to return this transaction form to the employer group plan administrator and may delay the requested effective date of coverage.
- 5. Return the completed Transaction Form along with any required documentation to: Membership, PO Box 2820, New York, NY 10116-2820.

Get more information at emblemhealth.com.

#### **HSA**

An HSA is a tax-free fund that can be used to pay for qualified medical and/or pharmacy expenses. EmblemHealth has partnered with Health Equity to provide this service for our customers with a high deductible health plan. Benefits include a full integration of enrollment and claim payment for only qualified high deductible health plans. Would you like to open employee HSA accounts with Health Equity? 

NO

#### HRA - Large Group Only

Health Reimbursement Arrangements (HRAs) are arrangements that allow an employer to reimburse for medical expenses paid by participating employees. HRAs reimburse only those items (copays, coinsurance, deductibles, prescription drugs, and services) agreed to by the employer which are not covered by the company's selected standard insurance plan. EmblemHealth has partnered with Health Equity to provide this service for our customers. Benefits include a full integration of enrollment and claim payment for only qualified high deductible health plans. Would you like to open an HRA account with Health Equity?

## **SECTION A** (To be completed by Benefits Administrator)

ACTION Check (✔)One	Qualifying Event	Documentation Required
Add Subscriber	New Hire or Change in Plan	For eligible employees who work at least 20 hours per week, provide a recent Copy of NYS-45 showing this subscriber as an employee or provide copy of payroll documentation reflecting the date, employee's name and Social Security #, or the employee's current-year W-4 Form.
Add Spouse	Marriage	If last name is different  ☐ Marriage Certificate ☐ 1040 Form
Add Dependent	Birth or Adoption	If last name is different ☐ Birth Certificate ☐ Formal Adoption Papers ☐ Court-Approved Guardianship Papers
Add Young Adult	Young Adult Coverage	Young Adult Election Form
Add Dependent	Dependent Adult Child Incapable of Self- Sustaining Employment	Disability Status Request Form
Add Spouse Add Dependent	Loss of Coverage	Certificate of Creditable Coverage
Add Domestic Partner	Domestic Partnership	Declaration of Cohabitation & Financial Interdependence Form

#### Donate Life Registry<sup>†</sup>

- You must select an option for yourself and any dependents applying for coverage
- Donate Life Registry for organ, eye, and tissue donation
- Dependents must be at least 16 years old in order to opt in for Donate Life Registry

Note: No exceptions to our retroactive enrollment period will be allowed. Small group members must be enrolled within 30 days from the Qualifying Event/next billing date (or within 90 days for large group members).

- \* I understand that the phone number(s) I provided on this form may be used by EmblemHealth or any of its contracted parties to contact me about my account, my health benefit plan or related programs, or services provided to me.
- \*\*Retiree option is applicable for large groups only.
- \*\*\*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.

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

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