



259 Monroe Avenue, Rochester, NY 14607
www.preferredcare.org

CHAMBER OF COMMERCE AND PROFESSIONAL ASSOCIATION ENROLLMENT APPLICATION

Please make sure to complete all six sections

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> APPLICATION FOR ENROLLMENT
<input type="checkbox"/> new hire
<input type="checkbox"/> open enrollment
<input type="checkbox"/> loss of coverage | <input type="checkbox"/> REQUEST FOR CHANGE
<input type="checkbox"/> change health plan
<input type="checkbox"/> add dependent
<input type="checkbox"/> remove dependent
<input type="checkbox"/> other _____ | <input type="checkbox"/> CANCEL COVERAGE
<input type="checkbox"/> open enrollment
<input type="checkbox"/> employment terminated
<input type="checkbox"/> moved out of area
<input type="checkbox"/> employee deceased
<input type="checkbox"/> other _____ | <input type="checkbox"/> COBRA/NYSC
<input type="checkbox"/> former employee
<input type="checkbox"/> former dependent |
|---|---|--|--|

I. SUBSCRIBER INFORMATION			
LAST NAME:	FIRST NAME:	M.I.:	
ADDRESS:			
CITY:	STATE:	ZIP:	COUNTY:
TELEPHONE:			
HOME:		WORK:	
SOCIAL SECURITY NUMBER:	MARITAL STATUS:	SEX:	
CURRENT HEALTH INSURANCE:			
HAVE YOU EVER BEEN A MEMBER OF PREFERRED CARE? <input type="checkbox"/> YES <input type="checkbox"/> NO			
CONTRACT NUMBER:			
HAVE YOU OR ANY OF YOUR DEPENDENTS BEEN COVERED BY ANOTHER HEALTH PLAN DURING THE LAST 63 DAYS (excluding any waiting periods)? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<ul style="list-style-type: none"> Please note, that a "No" answer means that expenses resulting from any conditions for which care was received or recommended during the last six months (excluding employer waiting period) will not be covered until you have completed a twelve (12) month waiting period. If you had prior coverage which terminated within 63 days of your effective date (excluding employer waiting period), your prior coverage may be eligible to satisfy all or part of your twelve (12) month waiting period. <u>Please complete the Previous Insurance Information section on the back and attach all qualifying documentation.</u> 			

- You must select a PCP in order for Preferred Care to properly administer coverage under your Preferred Care health plan unless you are a Preferred Care PPO member.

II. SUBSCRIBER and DEPENDENT INFORMATION				
	SUBSCRIBER	DEPENDENT	DEPENDENT	DEPENDENT
NAME (last if different) FIRST, MI				
BIRTHDATE (MM/DD/YY)	/ /	/ /	/ /	/ /
RELATIONSHIP (SPOUSE, CHILD)	SUBSCRIBER			
SOCIAL SECURITY NO.				
SEX	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
PRIMARY CARE PHYSICIAN NAME	(PCP)	(PCP)	(PCP)	(PCP)
(Females may also choose an OB/GYN)	(OB/GYN)	(OB/GYN)	(OB/GYN)	(OB/GYN)
PHYSICIAN SEQUENCE NUMBER (from Physician's listing)	(PCP) _____ (OB/GYN) _____	(PCP) _____ (OB/GYN) _____	(PCP) _____ (OB/GYN) _____	(PCP) _____ (OB/GYN) _____
PRIMARY CARE PHYSICIAN ADDRESS	(PCP)	(PCP)	(PCP)	(PCP)
	(OB/GYN)	(OB/GYN)	(OB/GYN)	(OB/GYN)
CURRENT PATIENT?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Will Accept	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Will Accept	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Will Accept	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Will Accept
FULL TIME STUDENT?		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A

III. PREVIOUS INSURANCE INFORMATION				
	SUBSCRIBER	DEPENDENT	DEPENDENT	DEPENDENT
EFFECTIVE DATE OF PREVIOUS COVERAGE:				
TERMINATION DATE:				
CARRIER'S NAME:				
IS MEMBER ELIGIBLE FOR MEDICARE?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

IV. ASSOCIATION/CHAMBER INFORMATION	
ASSOCIATION/CHAMBER NAME: _____	
<i>(PLEASE CIRCLE PLAN CHOICE):</i>	
Group HMO: Opportunity	TriVantage: Active Lifestyles
Basix	Family Focus
Community	Healthy Alternatives
Comprehensive	
PPO Plan: USdirect	CareFund HSA
	CareFund HRA
	Other: _____
DIVISION # _____	

V. MUST BE COMPLETED IN FULL BY EMPLOYER AND ASSOCIATION		
EMPLOYER NAME:		
EMPLOYER ADDRESS:		EMPLOYER PHONE NUMBER:
TAX ID NUMBER:	DOES EMPLOYEE MEET WAITING PERIOD CRITERIA? <input type="checkbox"/> YES <input type="checkbox"/> NO	
WHEN WAS EMPLOYEE HIRED? (N/A FOR RETIREE)	WHEN DID EMPLOYEE BECOME ELIGIBLE FOR COVERAGE? (N/A FOR RETIREE)	
EFFECTIVE DATE OF COVERAGE/CHANGE:	EMPLOYER SIGNATURE:	DATE OF SIGNATURE:
IS APPLICANT CURRENTLY WORKING AT LEAST 20 HRS/WEEK? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A FOR RETIREE Subscriber, including sole proprietor, must be employed a minimum of 20 hours per week in order to qualify for benefits under this contract.		
ASSOCIATION/CHAMBER VERIFICATION:		
SIGNATURE:		DATE:
PLEASE BE SURE YOUR APPROPRIATE DOCUMENTATION IS ATTACHED		

VI. AUTHORIZATION AND AGREEMENT	
<p>I certify that the information given on this form is correct to the best of my knowledge and I have read and agree to the authorization. I understand that Preferred Care (PC) may require verification of my employment with a bonafide employer, or as sole proprietor. I understand that benefits are not payable for expenses resulting from pre-existing conditions during the first twelve (12) months of coverage received, unless all or part of the twelve (12) month waiting period has been satisfied by prior coverage. If I have applied for an HMO plan, I understand that beginning on my effective date, I must get all my health care from PC Participating Providers, except for Emergency and Urgent Care. I understand that I must select a Primary Care Physician (PCP) who must coordinate my care in order to properly administer my benefits under the PC HMO coverage. I also understand that if I am applying for TriVantage Healthy Alternatives I am purchasing a POS insurance plan, in addition to my PC HMO coverage, which will require me to work with my physician to obtain any necessary precertification, while I am out of the service area. I understand that if I have applied for a USdirect PPO plan it is my responsibility to work with my physician and PC to obtain any necessary precertification. I also understand that I am applying for a PC Health Plan as specified on my application that is subject to the rules and guidelines as specified in that certificate/contract. I understand that my signature on this application means that I have read and understand the contents of this application. I hereby authorize any physician hospital or other medical facility or provider to release to PC any and all records and information regarding services requested while any of the persons on this contract are members of PC, and I also authorize the release of records and information relating to prior treatment and/or services. I represent to you that all information furnished by me on this form is true and complete to the best of my knowledge.</p>	
SUBSCRIBER SIGNATURE:	DATE:

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.