

SUBSCRIBER

Check Type of Coverage: Premier (CDPHP HMO) Plus (CDPHP HMO with UBI POS)		17 Columbia Circle • Albany, NY 12203-5190 • (518) 862-3700	we Dependent	<b>HORM</b> □ Termination	Add Dependent	Lati Liciation Cobra Continuation	│ □ New Enrollment	ENROLLMENT Check all that apply	
PPO (UBI) (For PPO, see reverse side for additional instructions)	Other: Effective Date:	☐ Dissatisfaction ☐ Cost ☐ Spouse's Coverage	☐ Open Enrollment—Transferred to another plan	☐ Employee Terminated ☐ Moved Out of Area	☐ Effective Date	☐ Qualifying Event/Reason:	□ New Hire □ Open Enrollment	Explanation and Effective Date	
uctions   Group Administrator Initials (required)	B. □ Active □ Retiree □ Salaried □ Union □ Other	Employee Status: A.   Full-time Part-time (hours per week)	Group / Division #:	Date coverage is to be effective:	☐ Union to non-union ☐ Other	☐ Part- to full-time ☐ Temporary to permanent	Date hired / Date of status change / /	EMPLOYER USE	

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	FORM	☐ Termination	☐ Employee Terminated ☐ Moved Out of A	☐ Moved Out of Area	vrea	Date coverage is to be effective:	ve:	THE TAXABLE CONTRACTOR WHEN THE REAL PROPERTY AND ADDRESS OF THE PARTY
ołumbia Circle • Albany, NY 12203-5190 • (518) 862-3700	3-5190 • (518) 862-3700		☐ Dissatisfaction [	□ Cost □ Spou	e's Coverage	Employee Status: A.  Full-time	time Part-time (hours per week)	ours per week)
HOUSE STREET, SHIPPING TO SHIPPING STREET, SHIPPING STREE		1	Other:	Effective Date:		B. ☐ Active ☐ Retiree ☐ Salaried	Union	Other
Coverage:	сорне нмо)	with UBI POS)	PPO (UBI) (For PPO, see reverse side for addition	everse side for additio	nal instructions)	Group Administrator Initials (required)	s (required)	
. First Name M.I.		Last Name	4. Your Social Security #	ity#		7. Employer Name	er Name	
. Street Address		Apt. #	5. Marital Status:	☐ Single ☐ Divorced	☐Separated ☐ Widowed	œ	Chamber/Association:	THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TRANSPORT NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TRANSPORT NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TRANSPORT NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TRANSPORT NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TRANSPORT NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TRANSPORT NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TRANSPORT NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TRANSPORT
				☐ Married: Date of M	9			
3. City State		County Zip Code	ode 6. Telephone:		THE CHARLES OF STREET STREET, STREET STREET, S	9. Type of c	Type of coverage you are applying for	lying for:
		×	Home: ( )	- W	Work: ( ) -	☐ Individual	dual 🗆 Family	
	Date of Birth		Medicare A & B*		Select a Primary Care Physician. You, and each	íou, and each		
		o ) ).	*Copy of		dependent, must select one Primary Care Physici Female members may also choose one OB/GYN.	e one OB/GYN.		
by Name: Indicate different last names, if De applicable. List oldest dependents first.	dents over age 18 must	Social Security	Medicare Card must be	Time and the l	For all selections, indicate if you are a current patient and the PCP #/Group # from the provider directory.	are a current patient provider directory.	DO Nimber	Group Location cur
□ □ 00 Applicant		Self	□A / /	PCP				A A A A A A A A A A A A A A A A A A A
	/ / [		□ B / /	OB/GYN	2,	THE THE STATE OF T		
01		Husband	] A	PCP	THE PROPERTY OF THE PROPERTY O	The state of the s		,
	, ,	Other	□B / /	OB/GYN	Ζ,			
		Son	□A / /	□ Yes PCP	OR PERSON NAMED AND A SECURE AND A SECURE AND A SECURE ASSESSMENT AND A SECURE ASSESSMENT ASSESSMEN			
	/ / [	☐ Daughter	□8 / /	□N₀ OB/GYN		A MARAMATAN AND AND AND AND AND AND AND AND AND A		
□ □ 03		Son	□A / /	☐ Yes PCP	The second secon	THE CONTRACT CONTRACT OF THE C		
	/ / [	□ Daughter	□ <b>B</b> / /	□No OB/GYN	2	manus and an analysis of the second pay indicates and an an analysis of the second pay in the second p		
□ □ 04		Son	□A / /	☐ Yes PCP	and the second s	Andreada de Carlos de Constante de La Carlos de Car	-	
	/ /	□ Daughter	□B / /	□No OB/GYN	۷.			
Do your dependents reside in your home? $\square$ Yes $\square$ No $\square$ If no, give address(es):	ome? es):		Other be ma	Other Coverage—Do you, your spouse be maintained in addition to CDPHP?	, or any o ☐ Yes	f your dependents have any oth	any other medical in below.	surance that will
			Policy	Policyholder name:	J. Common of the	Relationship:	A MANAGE 18 AND ADMINISTRATION OF THE PARTY	THE PRINCIPAL PROPERTY AND ADDRESS AND ADD
Full-time college students age 19 and over:		Expected Date of Graduation:	E	THE REAL PROPERTY OF THE PROPE		□ Self □ Spouse	se □ Child	
School Name and Address:				Social Security Number:		Date of Birth:		
Do you have a disabled dependent beyond age 197 □ No □ Yes (list name[s]):	eyond age 19?		ER INSU	Insurance Carrier:		Policy #:	H3	Effective Date:
AGREEMENT: I have read and agree	ee to the authorization on	the reverse side of this form.	Address	ess:		Employer Name:	.7	
Applicant's Signature	Adult Dependent Signature	dent		Covered Individuals:	PRODUCTION OF THE PROPERTY OF		COMMISSION OF THE REAL PROPERTY OF THE PROPERT	
Adult Dependent Signature	Adult Dependent Signature	dent ure	Plan Type:	an Type: □ Self Only □ Self & Family	Co	Coverage Type:	al Drug Dental	ntal 🗆 Vision

10. MEMBER INFORMATION

CDPHP Companies: Capital District Physicians' Health Plan, Inc. (CDPHP); CDPHP Universal Benefits, Inc. (UBI)
ORIGINAL TO BE FORWARDED TO CDPHP

13. SIGNATURES

11. DEPENDENT