EMPLOYEE ENROLLMENT FORM

(Please print & complete in full to avoid any delays)

Easy Choice HEALTH PLAN OF NEW YORK

45 Broadway, Suite 300
New York, NY 10006
Tel: (212) 747-0877
www.atlantishp.com

PLAN OPTION:	☐ HMO ☐ POS ☐ HNY	TYPE OF COVERAGE:	☐ SINGLE ☐ COUPLE ☐ PARENT/CHILD ☐ FAMILY

EMPLOYEE INFORMATION

Last Name	First Name	MI	Date Of Birth	Sex ☐ M ☐ F

Social Security Number	Email Address

Home Address	Apt. No.	City	State	Zip Code

Primary Phone Number	Alternate Phone	Primary Care Physician Name & ID	If married, date of marriage:

Name of Employer	Business Phone

TYPE OF ACTIVITY

☐ New Subscriber ☐ Change of Plan or Primary Care Physician ☐ Termination

☐ Add / Remove Spouse, Dependent Child Reason: _____ Date: _____

DEPENDENT INFORMATION (Please use another enrollment form if you have more dependents)

	Add / Remove	Last Name, First Name, MI	Sex	Date of Birth	Social Security	Primary Care Physician Name & ID
SUBSCRIBER	☐ / ☐			/ /		
SPOUSE	☐ / ☐			/ /		
CHILD 1.	☐ / ☐			/ /		
CHILD 2.	☐ / ☐			/ /		
CHILD 3.	☐ / ☐			/ /		
CHILD 4.	☐ / ☐			/ /		

STUDENT INFORMATION

If dependent children listed are age 19 or older, do they attend school on a full-time basis? ☐ Yes ☐ No	If yes, list first name of child and school	Is any dependent disabled? ☐ Yes ☐ No	If yes, list first name of child

OTHER INSURANCE INFORMATION

Do you, your spouse or dependent children have other Health Insurance? ☐ Yes ☐ No	Name of Insured	Name of Insurance carrier & Policy No.

Give Name of Prior Insurer and Date of Termination	Proof of Prior Coverage

EMPLOYER INFORMATION

Name of Group	Group Number	Contract Plan

Employment Hire Date	Enrollment Effective Date	Date Submitted to AHP	Approved by (employer representative signature):

Is employee active at work? ☐ Yes ☐ No Hours worked per week _____	Move coverage to COBRA: ☐ Yes ☐ No	Qualifying event: _____ Qualifying date: _____

I authorize deductions from my earnings for any required contributions. I authorize all health professionals to provide Easy Choice Health Plan of New York and its contracted professionals, information about health (including mental illness) care advice, treatment or supplies provided to me or my dependents relating to coverage for the purpose of coordinating patient care, evaluating and administering claims for benefits, and for fulfilling Easy Choice Health Plan of New York's obligations under state and federal law. I will discuss any questions concerning the plan with Easy Choice Health Plan of New York 's member services. My signature below affirms eligibility for coverage, and all that information provided is full, complete and true to the best of my knowledge.

I understand that any person who knowingly with intent to defraud any insurance 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 material fact thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed $5,000 and that stated value of the claim for each such violation.

In the absence of creditable coverage Pre-existing Medical Conditions may not be covered for 11 months from the initial enrollment date.

EMPLOYEE/APPLICANT SIGNATURE: X _____ DATE: _____

READ THE FOLLOWING STATEMENTS VERY CAREFULLY.

YOUR SIGNATURE(S) ON THIS PAGE INDICATE(S) THAT YOU HAVE READ, UNDERSTAND, AND AGREE TO ALL OF THE PROVISIONS SET FORTH ON THIS APPLICATION. PLEASE SIGN AND DATE.

A. Coverage Request: I/We hereby request coverage of the type indicated in the attached application. If this request is for a family contract, the names of my spouse and eligible dependent children are listed. I make this application on their behalf as well as my own. If this request is accepted, coverage will be effective only if my payment of the subscription charge is paid in full to Easy Choice Health Plan of New York.

B. Statement of Fidelity: I/We affirm that all attached documents, statements, and answers in this application are true and are representations made to induce the issuance of the contract applied for. If accepted, this application will be part of the contract. The contract will become effective on the date specified on the identification card or the identification stub. Any misrepresentation by me of facts which are material to this application may result in rescission of this contract.

C. Pre-Existing Conditions: I/We understand that there will be an 11 month waiting period for benefits for any physical or mental condition, regardless of the cause, for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on my/our enrollment date for this coverage. Credit for prior creditable coverage will be applied to this waiting period if such coverage was continuous to a date not more than 63 days prior to my/our enrollment date for this coverage. In the case of previous health insurance coverage, any affiliation period prior to that previous coverage becoming effective will also be credited. Upon request, I/we must provide appropriate documentation of prior coverage to Easy Choice Health Plan of New York.

D. Privacy Statement: I/We authorize any health care provider, payer of health and health related claims, or government agency to furnish to Easy Choice Health Plan of New York or its designee all records pertaining to medical history, services rendered, and payments made regarding me or my dependents for review and evaluation of any claim, or services in conjunction with managed care. I/We authorize Easy Choice Health Plan of New York to disclose such information to my/our physician; another payer or self-insurer, and if my/our coverage is under a group contract held by an employer, association, trust fund, or similar entity, to the group contract holder, or to an Easy Choice Health Plan of New York designee for purposes of continuity of care and medical management, disease management, managed disability coordination or financial audits.

E. Effective Date: I/We acknowledge that the effective date stated on the attached agreement is in effect upon approval of the underwriting department. Although membership identification cards may not be issued by the effective date of the policy, if they are received within 30 days of the said effective date then no change to the agreed upon effective date will occur.

F. Voluntary Termination: If this coverage is issued, I/we may make a written request to cancel the contract within 10 days after receipt. I understand that any medical services rendered during this time will not be covered. Thereafter, I understand that 30 days advance written notification to Easy Choice Health Plan of New York is required to terminate coverage.

All statements and answers in this application are true, and are representations made to induce the insurance of coverage. Any misrepresentation of material fact may result in cancellation or rescission of coverage.

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 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. I have read, understand, and agree to all the provisions set forth.

Signature _____ Date _____

Spouse's Signature _____ Date _____

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"Easy Choice Health Plan of New York" is a marketing name for Atlantis Health Plan, Inc.