Small Group Employee Change Form

Empire BlueCross
An Anthem Company

Consult the Booklet or Certificate of Coverage for complete coverage terms and conditions. Complete electronically or in black ink and return to your employer. Please use extra sheets of paper if necessary.

Section A: Employer and Employee Information				
Employer name			Employer tax ID no.	
Employee home address — Street or P.O. Box if applicable		City	County	State / ZIP code
Retired? ☐ Yes ☐ No	Primary phone no.	Employee email address		

I'm providing my email address because **I want to receive information about my benefits electronically**. These communications may include Identification (ID) Cards, Certificates of Coverage, billing invoices, Explanation of Benefits, required notices including cancellations and renewals, and helpful or specific personalized information to help get the most out of the benefits. I understand I need to register on www.empireblue.com or the Empire mobile app to get the most out of my plan's digital tools, and I will make sure Empire has my most up to date email address. I understand that I can update my email address, communication preferences, and request free copies of any materials by going to www.empireblue.com or calling the Member Services number on my ID card.

Reason for change(s) — Select all that apply.

☐ Address change	☐ Cancel Spouse/Domestic Partner or dependent	☐ Enrollment in Medicare (Fill in Section C)
☐ Name change	☐ Change Primary Care Physician (PCP)	☐ Cancel all coverage
☐ Benefit change	☐ Change Primary Care Dentist (PCD)	☐ Cancel product(s)
☐ Add Spouse/Domestic Partner or dependent		☐ Other: _____

Event reason — Select all that apply.

☐ Open enrollment*	☐ Birth of child	☐ Involuntary loss of coverage	☐ Termination of employment
☐ Marriage	☐ Adoption of child	☐ Other insurance	☐ Termination of other group plan
☐ Divorce	☐ Death	☐ Court ordered coverage	☐ Other[2]: _____

Event date: _____/_____/_____ **(MM/DD/YYYY)** *Leave Event Date field blank.

Effective date is subject to terms of the Booklet or Certificate of Coverage. See "When Coverage Begins" under "Who is Covered."

Section B: Employee and Dependent Type of Coverage and Coverage Information — Complete this section for you and dependents to be covered. All fields required. Attach a separate sheet if necessary.

Enrollee	**Employee/Subscriber**	**Spouse/Domestic Partner/Dependent*** ☐ Add ☐ Change ☐ Cancel
Social Security no.[1]	- -	- -
Birthdate (MM/DD/YYYY)	/ /	/ /
Last name		
First name, Middle initial		
Gender	☐ Male ☐ Female ☐ Gender X	☐ Male ☐ Female ☐ Gender X
Check all that apply:		☐ Spouse ☐ Domestic Partner ☐ Dependent
*Enter dependent's address, if different:		
Medical Coverage		
Medical contract code		
Primary Care Physician (PCP) name[3]		
PCP ID no.		
Existing patient	☐ Yes ☐ No	☐ Yes ☐ No

1 Empire BlueCross (Empire) is required by the Internal Revenue Service to collect this information.
2 See Booklet or Certificate of Coverage description of "Special Enrollment Periods" under "Who is Covered" for other event reasons.
3 To select a PCP and/or PCD, visit our website at www.empireblue.com/find-doctor. If your Empire benefit plan requires you to pick a PCP and/or PCD and you do not select one, we will assign one to you. You will be able to change to another PCP and/or PCD by contacting us.

Employee name: _____ Social Security no.: _____-_____-_____

Dental Coverage		
Enrollee	**Employee/Subscriber**	**Spouse/Domestic Partner/Dependent**
Dental contract code		
Primary Care Dentist (PCD) name[3]		
PCD ID no.		
Existing patient	☐ Yes ☐ No	☐ Yes ☐ No
Vision Coverage		
Vision contract code		

Section C: Prior and Other Group Coverage — Attach a separate sheet if necessary.

Is anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ No If yes, give name: _____

Medicare ID no.	Part A effective date (MM/DD/YYYY) / /	Part B effective date (MM/DD/YYYY) / /	Medicare eligibility reason(select all that apply) ☐ Age ☐ Disability ☐ End-stage renal disease: Onset date (MM/DD/YYYY) _____/_____/_____

Medicare Part D ID no.	Medicare Part D Carrier	Part D effective date (MM/DD/YYYY) / /

Is anyone applying for coverage covered by other health insurance? ☐ Yes ☐ No If yes, please provide the following:

Name of person covered (Last, First, M.I.)	Type (select one)	Coverage (select all that apply)	Insurer name	Policy ID no.	Dates (if applicable) (MM/DD/YYYY)
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia			Start: ____/_____/_____ End: ____/_____/_____
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia			Start: ____/_____/_____ End: ____/_____/_____

Section D: Terms, Conditions and Authorizations

In signing this application I represent that: I have read, or have had read to me, the completed application, and I realize any false statement or misrepresentation may result in loss of coverage. I certify each Social Security Number listed on this application is correct.

By providing a phone number, I agree and consent that Empire and its affiliates may call or text me at the phone number included on this application using an automated telephone dialing system and/or prerecorded message to help keep me informed about my benefits.

As an eligible employee, I request coverage for myself and eligible dependents listed and authorize my employer to deduct any required contributions for this insurance from my earnings. I understand all benefits are subject to conditions stated in my employer's Group Contract and my Booklet or Certificate of Coverage.

INSURANCE FRAUD STATEMENT: 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.

Sign here	**Applicant signature** X	**Today's date (MM/DD/YYYY)** / /
	Company officer signature X	**Today's date (MM/DD/YYYY)** / /
	Printed name	**Group no.**

3 To select a PCP and/or PCD, visit our website at www.empireblue.com/find-doctor. If your Empire benefit plan requires you to pick a PCP and/or PCD and you do not select one, we will assign one to you. You will be able to change to another PCP and/or PCD by contacting us.

We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

Spanish
Usted tiene derecho a recibir ayuda en su idioma en forma gratuita. Simplemente llame al número de Servicios para Miembros que figura en su tarjeta de identificación.

Chinese
您有權免費獲得透過您使用的語言提供的幫助。請撥打您的 ID 卡片上的會員服務電話號碼。若您是視障人士，還可索取本文件的其他格式版本。

Vietnamese
Quý vị có quyền nhận miễn phí trợ giúp bằng ngôn ngữ của mình. Chỉ cần gọi số Dịch vụ dành cho thành viên trên thẻ ID của quý vị. Bị khiếm thị? Quý vị cũng có thể hỏi xin định dạng khác của tài liệu này."

Korean
귀하는 자국어로 무료지원을 받을 권리가 있습니다. ID 카드에 있는 멤버 서비스번호로 연락하십시오.

Tagalog
May karapatan ka na makakuha ng tulong sa iyong wika nang libre. Tawagan lamang ang numero ng Member Services sa iyong ID card. May kapansanan ka ba sa paningin? Maaari ka ring humiling ng iba pang format ng dokumentong ito.

Russian
Вы имеете право на получение бесплатной помощи на вашем языке. Просто позвоните по номеру обслуживания клиентов, указанному на вашей идентификационной карте. Пациенты с нарушением зрения могут заказать документ в другом формате.

Armenian
Դուք իրավունք ունեք ստանալ անվճար օգնություն ձեր լեզվով: Պարզապես զանգահարեք Անդամների սպասարկման կենտրոն, որի հեռախոսահամարը նշված է ձեր ID քարտի վրա:

Farsi
"شما این حق را دارید تا به صورت رایگان به زبان مادری تان کمک دریافت کنید. کافی است با شماره خدمات اعضا (Member Services) درج شده روی کارت شناسایی خود تماس بگیرید." دچار اختلال بینایی هستید؟ می توانید این سند را به فرمت های دیگری نیز درخواست دهید.

French
Vous pouvez obtenir gratuitement de l'aide dans votre langue. Il vous suffit d'appeler le numéro réservé aux membres qui figure sur votre carte d'identification. Si vous êtes malvoyant, vous pouvez également demander à obtenir ce document sous d'autres formats.

Arabic
لك الحق في الحصول على مساعدة بلغتك مجانًا. ما عليك سوى الاتصال برقم خدمة الأعضاء الموجود على بطاقة الهوية. هل أنت ضعيف البصر؟ يمكنك طلب أشكال أخرى من هذا المستند.

Japanese
お客様の言語で無償サポートを受けることができます。IDカードに記載されているメンバーサービス番号までご連絡ください。

Haitian
Se dwa ou pou w jwenn èd nan lang ou gratis. Annik rele nimewo Sèvis Manm ki sou kat ID ou a. Èske ou gen pwoblèm pou wè? Ou ka mande dokiman sa a nan lòt fòma tou.

Italian
Ricevere assistenza nella tua lingua è un tuo diritto. Chiama il numero dei Servizi per i membri riportato sul tuo tesserino. Sei ipovedente? È possibile richiedere questo documento anche in formati diversi

Polish
Masz prawo do uzyskania darmowej pomocy udzielonej w Twoim języku. Wystarczy zadzwonić na numer działu pomocy znajdujący się na Twojej karcie identyfikacyjnej.

Punjabi
ਆਪਣੀ ਭਾਸ਼ਾ iਵੱਚ ਮੁਫ਼ਤ iਵੱਚ ਮਦਦ ਹਾਂiਸਲ ਕਰਨ ਦਾ ਿਅਧਕਾਰ ਹੈ। ਬਸ ਆਪਣy ਆਈਡੀ ਕਾਰਡ ਤੇ iਦੱਤੇ ਸਿਰਵਸ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। ਨਜ਼ਰ ਕਮਜ਼ੋਰ ਹੈ? ਤੁਸ ਇਸ ਦਸਤਾਵੇਜ਼ ਦੇ ਹੋਰ ਰੂਪਾਂਤਰ ਮੰਗ ਸਕਦੇ ਹੋ।

TTY/TTD:711

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. By calling Member Services, our members can get free in-language support, and free aids and services if you have a disability. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed in any of these areas, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf