

# Empire is becoming Anthem

## New name. Same commitment to you.

On January 1, 2024, Empire HealthChoice Assurance, Inc. will become Anthem HealthChoice Assurance, Inc. doing business as Anthem Blue Cross and Blue Shield.

Empire HealthChoice has been part of the Anthem family of health plans since 2006. Our new name reinforces our commitment to improve the whole health of the people we serve. It combines the industry-leading Anthem name, with the strength and value of the brand that generations of New Yorkers have come to know and trust. To learn more, please visit [empireblue.com/faq](https://empireblue.com/faq).

Please note that since the name change will go into effect on January 1, 2024, the application for 2024 enrollment reflects the new name.

## Small Group Employee Enrollment Application



The employee who completes this application is solely responsible for its accuracy and completeness. Be sure to answer all questions and to sign and date your application. Please complete in black ink only.

### Section A: Employer and Employee Information

Employer name

Employment status

☐ Full-time ☐ Part-time ☐ Retired

Date of hire (MM/DD/YYYY)

/ /

Date waiting period begins (MM/DD/YYYY)

/ /

Employee home address — Street or P.O. Box if applicable

City

County

State

ZIP code

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 [anthembluecross.com](http://anthembluecross.com) or the Anthem mobile app to get the most out of my plan's digital tools, and I will make sure Anthem has my most up to date email address. I understand that I can update my email addresses, change my communication preferences, and request free copies of any materials at any time by going to [anthembluecross.com](http://anthembluecross.com) or calling the Member Services number on my ID card.

**You must fill out the following section: Would you like to be added to the Donate Life Registry?**

☐ YES or ☐ SKIP THIS QUESTION

**Application type — Select one:** ☐ New enrollment ☐ Open enrollment ☐ COBRA ☐ Rehire date (MM/DD/YYYY) \_\_\_\_/\_\_\_\_/\_\_\_\_

**Language choice (optional):** ☐ English ☐ Spanish ☐ Chinese ☐ Korean ☐ Other — please specify: \_\_\_\_\_

**Select qualifying event for special enrollment by employee, spouse or dependent child.**

☐ Mandatory Right of Election to continue Dependent coverage through age 29 (qualified dependents only)

**Loss of coverage in other group plan due to:**

☐ Loss of dependent child status

☐ Reduction in hours

☐ Gain or become a dependent via marriage, birth or adoption

☐ Death of spouse

☐ COBRA/State continuation is exhausted

☐ Loss of or become eligible for Medicaid or Child Health Plus

☐ Employer ends plan contributions

☐ Employment termination

☐ Other group plan ends

☐ Legal separation, divorce or annulment

**Select qualifying event for COBRA:**

☐ Death of subscriber

☐ Employee becomes eligible for Medicare

☐ Divorce or legal separation from subscriber

☐ Employment termination

☐ Reduction in hours

☐ Loss of dependent child status

**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*	Dependent*
Social Security no. <sup>1</sup>	- -	- -	- -	- -
Birthdate (MM/DD/YYYY)	/ /	/ /	/ /	/ /
Last name				
First name, Middle initial				
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender X	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender X	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender X	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender X
Check all that apply:		<input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Young adult <sup>2</sup>	<input type="checkbox"/> Young adult <sup>2</sup>
*Enter dependent's address, if different:				

If your overage adult dependent is impaired, complete the NY Handicapped/Dependent Form (HAC 506), which can be found at <https://www.anthembluecross.com/employer/forms/>.

**Medical Coverage** — Indicate the contract code for the medical plan selected. Your employer will advise you of your plan options and contract codes.

Enrollee	Employee/Subscriber	Spouse/Domestic Partner	Dependent	Dependent
Medical contract code				
Enrollment status	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive
Primary Care Physician (PCP) name <sup>3</sup>				
PCP ID no.				
Existing patient	<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

**Dental Coverage**

Dental contract code				
Enrollment status	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive
Primary Care Dentist (PCD) name <sup>3</sup>				
PCD ID no.				
Existing patient	<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

**Vision Coverage**

Vision contract code				
Enrollment status	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive

<sup>1</sup> Anthem Blue Cross and Blue Shield (Anthem) is required by the Internal Revenue Service to collect this information.

<sup>2</sup> Your dependent between ages 26-30 may be covered if your employer has chosen this option or if you or your eligible dependent buy extended coverage through age 29.

<sup>3</sup> To select a PCP and/or PCD, visit our website at [www.anthembluecross.com/find-doctor](http://www.anthembluecross.com/find-doctor). If your Anthem 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.

**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) <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> 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)
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia			Start: ____/____/____ End: ____/____/____
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia			Start: ____/____/____ End: ____/____/____
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia			Start: ____/____/____ End: ____/____/____
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia			Start: ____/____/____ End: ____/____/____

**Section D: Terms, Conditions and Authorizations** — Please read this section carefully before signing the application.

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.

**I understand that I am required to pay member cost share as required by my benefit plan.**

By providing a phone number, I agree and consent that Anthem 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 Certificate of Coverage.

**Special Enrollment Rights — Medical Coverage Only.** If you declined enrollment for yourself or your dependent(s) (including a spouse) because of other group health plan coverage, you can enroll yourself and your dependent(s) in this plan if you or your dependent(s) lose eligibility for the other group health plan due to any of the following: termination of employment; termination of the other group health plan; death of your Spouse; legal separation, divorce or annulment; reduction of hours of employment; employer contributions toward the group health plan were terminated; or a child no longer qualifies for coverage as a child under the other group health plan. You must request enrollment within 31 days after the other coverage ends (or after the employer contributions ends).

You may also enroll 31 days from the date your exhaust COBRA or state continuation coverage. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll yourself and your dependent(s) starting on the date of birth if you request enrollment within 60 days after the birth, adoption or placement for adoption. Otherwise, coverage begins on the date we receive notice of the birth or adoption, provided you pay additional premium when due.

If you get married while covered, you can add your Spouse effective on the date of your marriage if you tell us within 31 days. You, your Spouse or child can also enroll within 60 days of the occurrence of the following circumstances: You or Your Spouse or Child loses eligibility for Medicaid or Child Health Plus; or You or Your Spouse or Child becomes eligible for Medicaid or Child Health Plus.

**Health Savings Account:** If you want to establish a Health Savings Account (HSA) with an HSA-compatible health plan, a bank needs to act as the HSA financial custodian. By signing below you hereby authorize the financial custodian to provide Anthem with information about your HSA, including account no., account balance and information about account activity. You may revoke this authorization at any time in writing.

**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.

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

# 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 무료 지원을 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 مجاناً. 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 fòm 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 ਵਿੱਚ ਮੁਫਤ ਸੇਵਾਵਾਂ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਆਪਣਾ ਅਧਿਕਾਰ ਹੈ। ਬਸ ਆਪਣਾ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ 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>