

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.

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 Employer Benefit Plan Change Form For Groups of 1-100¹



Section 1: Group information

Group name		
Effective date: (MM/DD/YYYY): / /	Group no.	Employer tax ID no. (required)

Section 2: I have demographic changes to my current plan. Please update the following:

Change phone no. to:	Change group address to (select one or both as applicable): <input type="checkbox"/> Company Street Address: <input type="checkbox"/> Billing Address (if different from above):
Change primary group contact to:	Change primary email address to:
Add group contact:	Other:

Section 3: I have probationary period/waiting period changes to my current plan. Please update the following:

<input type="checkbox"/> New Hire	<input type="checkbox"/> None (Date of Hire ²) <input type="checkbox"/> 1 month <input type="checkbox"/> 2 months <input type="checkbox"/> 30 days <input type="checkbox"/> 45 days ³ <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> First of month following completion of waiting period/probationary period (not applicable for "90 days" option) <input type="checkbox"/> Day following completion of waiting period/probationary period (not applicable for "None (Date of Hire ²)" option)
<input type="checkbox"/> Rehired	<input type="checkbox"/> None (Date of Hire ²) <input type="checkbox"/> 1 month <input type="checkbox"/> 2 months <input type="checkbox"/> 30 days <input type="checkbox"/> 45 days ³ <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> First of month following completion of waiting period/probationary period (not applicable for "90 days" option) <input type="checkbox"/> Day following completion of waiting period/probationary period (not applicable for "None (Date of Hire ²)" option)

Section 4: Medical/Vision/Dental benefit change authorization

Fill out this section if you would like to choose a plan that was not shown in your renewal options. Please note your benefit selection(s) below and submit a signed quote.
If you want to accept the renewal coverage we already proposed, **no action is needed.**
For employers providing a Health Savings Account (HSA) option (only one choice is allowed)
Do you want Anthem to disclose your group's data to its banking services provider to establish Health Savings Accounts?
 Yes (Requires completion of the Consumer Driven Health Plans (CDHP) questionnaire) No
I would like to make the following benefit change(s) upon my group's renewal:

Current plan name	Current contract code	Renewal plan name	Renewal contract code

Section 5: Riders — Check all that apply

Add Domestic Partner Rider Add Age 29 Rider Remove Domestic Partner Rider Remove Age 29 Rider

¹ A small group must have at least one active full-time equivalent employee that meets the definition of employee in 42 U.S.C. 300gg-91(d)(5) but no more than 100 employees. At least one full-time common law employee must be enrolled. Groups where the only enrollees would be the sole owner of a business or the owner and/or his/her spouse are not eligible.
² First day of active employment for pay.
³ 45 days is the maximum waiting period allowed for Healthy New York coverage.

Section 6: Disclaimer language

Certification

By signing below, I certify that all statements contained in this form are true and accurate to the best of my knowledge. I further certify that I am an officer or owner of the business and duly authorized to execute this certification on behalf of the business.

Access of Group Information by Designated Agent/Producer/Broker/Agency/Brokerage/General Agency

We the employer hereby authorize our designated agent, producer, broker, agency, brokerage, general agency and their respective employees currently on file with Anthem (Agent) to access our health plan information, including protected health information, on behalf of our health plan through Anthem's EmployerAccess system or any other access points Anthem may offer. This information may include, but is not limited to, detail about members, plan selections and bills/invoices. Our Agent is also authorized to make changes to our information on our behalf, including but not limited to adding/deleting plans and members and changing member demographic information. We will be responsible for the activities of our Agent. If our Agent on file changes, these authorizations will apply with respect to our successor Agent. Our Agent is required to maintain all original documentation and will make such documentation available to Anthem upon request.

Select this box **ONLY** if the employer DOES NOT want to authorize the agent/producer/broker/general agent to access and change the group's information on behalf of the group. **Do not select this box if you consent.**

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	Company officer signature	Printed name	
	X		
Title	Group no.	Today's date (MM/DD/YYYY)	

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。若您為視障人士，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 ਅਧਿਕਾਰ ਹੈ। ਬਸ ਆਪਣੇ 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>