PLEASE USE BLACK INK ONLY. *For address changes and/or primary care physician changes simply call (518) 641-3700 or 1-800-777-2273. There is no need to complete this form.*

CDPHP

Enrollment Application/ Change Form

Patroon Creek Corporate Center
1223 Washington Avenue • Albany, NY 12206-1057
(518) 641-5000 or 1-800-993-7299

EXPLANATION

Check all that apply	Explanation and Effective Date
☐ New Enrollment ☐ Name Change ☐ Cobra Continuation ☐ Add Dependent	☐ New Hire ☐ Open Enrollment ☐ Qualifying Event/Reason: ____ ☐ **Effective Date** ____
☐ Termination ☐ Remove Dependent Only	☐ Employee Terminated ☐ Moved Out of Area ☐ Open Enrollment—Transferred to another plan ☐ Dissatisfaction ☐ Cost ☐ Spouse's Coverage ☐ Other: ____ **Effective Date:** ____

EMPLOYER USE

Date hired ___ /___ /___ Date of status change ___ /___ /___

☐ Part- to full-time ☐ Temporary to permanent

☐ Union to non-union ☐ Other ____

Date coverage is to be effective: ____

Group/Division # : ___ ___ ___ ___ ___ ___ ___ - ___ ___ ___ ___

Employee Status: A. ☐ Full-time ☐ Part-time *(hours per week)* ____

B. ☐ Active ☐ Retiree ☐ Salaried ☐ Union ☐ Other

Group Administrator Initials *(required)* ____

Check Type of Coverage: ☐ **Premier (CDPHP HMO)** ☐ **Plus (CDPHP HMO with UBI POS)** ☐ **Paragon (UBI POS)**

SUBSCRIBER

1. First Name M.I. Last Name
2. Street Address Apt. #
3. City State County Zip Code

4. Your Social Security # ___ ___ ___ – ___ ___ – ___ ___ ___ ___

5. Marital Status: ☐ Single ☐ Divorced ☐ Separated ☐ Widowed
☐ Married: Date of Marriage ____ /____ /____

6. Telephone:
Home: ( ) – Work: ( ) –

7a. Employer Name

7b. Chamber/Association

8. Type of coverage you are applying for: ☐ Individual ☐ Family

9. Primary language if other than English:

10. MEMBER INFORMATION

You, and each dependent, **must** select a **Primary Care Physician (PCP)**. Females may also choose one OB/GYN. For all selections, indicate if you are a current patient and the PCP # from the provider directory.

Add	Delete	Name: Indicate different last names, if applicable. List oldest dependents first. First M.I. Last	Date of Birth (mm/dd/yy) ***All dependents over age 18 must sign below***	Relationship	Social Security Number	Medicare A & B* Effective Date ****Copy of Medicare Card must be attached.***	Full-Time Student	**PCP First and Last Name**	**Office Location**	PCP Number	✔ if current patient
☐	☐	00 Applicant	/ /	Self ☐ M ☐ F		☐ A / / ☐ B / /		PCP OB/GYN			☐ ☐
☐	☐	01	/ /	☐ Husband ☐ Wife ☐ Other		☐ A / / ☐ B / /		PCP OB/GYN			☐ ☐
☐	☐	02	/ /	☐ Son ☐ Daughter		☐ A / / ☐ B / /	☐ Yes ☐ No	PCP OB/GYN			☐ ☐
☐	☐	03	/ /	☐ Son ☐ Daughter		☐ A / / ☐ B / /	☐ Yes ☐ No	PCP OB/GYN			☐ ☐
☐	☐	04	/ /	☐ Son ☐ Daughter		☐ A / / ☐ B / /	☐ Yes ☐ No	PCP OB/GYN			☐ ☐

11. DEPENDENT

Do your dependents reside in your home?
☐ Yes ☐ No If no, give address(es):

Full-time college students age 19 and over: Expected Date of Graduation:
School Name and Address:

Do you have a disabled dependent beyond age 19?
☐ No ☐ Yes (list name[s]):

12. OTHER INSURANCE

Other Coverage—Do you, your spouse, or any of your dependents have any other medical insurance that will be maintained in addition to CDPHP? ☐ **Yes** ☐ **No** **If yes, complete below.**

Policyholder name:

Relationship: ☐ Self ☐ Spouse ☐ Child

Social Security Number:

Date of Birth: / /

Insurance Carrier:

Policy #:

Effective Date:

Address:

Employer Name:

Covered Individuals:

Plan Type: ☐ Self Only ☐ Self & Family

Coverage Type: ☐ Hospital ☐ Medical ☐ Drug ☐ Dental ☐ Vision

13. SIGNATURES

AGREEMENT: I have read and agree to the release on the reverse side of this form.

Applicant's Signature ____ Date ____
Adult Dependent Signature ____ Date ____
Adult Dependent Signature ____ Date ____
Adult Dependent Signature ____ Date ____

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

Form 5315-0901

ORIGINAL TO BE FORWARDED TO CDPHP

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Enrollment Application/ Change Form

Patroon Creek Corporate Center
1223 Washington Avenue • Albany, NY 12206-1057
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EXPLANATION

Check all that apply	Explanation and Effective Date
☐ New Enrollment ☐ Name Change ☐ Cobra Continuation ☐ Add Dependent	☐ New Hire ☐ Open Enrollment ☐ Qualifying Event/Reason: ___ ☐ **Effective Date** ___
☐ Termination ☐ Remove Dependent Only	☐ Employee Terminated ☐ Moved Out of Area ☐ Open Enrollment—Transferred to another plan ☐ Dissatisfaction ☐ Cost ☐ Spouse's Coverage ☐ Other: ___ **Effective Date:** ___

EMPLOYER USE

Date hired ___ /___ /___ Date of status change ___ /___ /___

☐ Part- to full-time ☐ Temporary to permanent

☐ Union to non-union ☐ Other ___

Date coverage is to be effective: ___

Group/Division # : ___ ___ ___ ___ ___ ___ ___ - ___ ___ ___ ___

Employee Status: A. ☐ Full-time ☐ Part-time *(hours per week)* ___

B. ☐ Active ☐ Retiree ☐ Salaried ☐ Union ☐ Other

Group Administrator Initials *(required)* ___

Check Type of Coverage: ■ Premier (CDPHP HMO) ■ Plus (CDPHP HMO with UBI POS) ■ Paragon (UBI POS)

SUBSCRIBER

1. First Name M.I. Last Name	4. Your Social Security # ___ ___ ___ – ___ ___ – ___ ___ ___ ___	7a. Employer Name
2. Street Address Apt. #	5. Marital Status: ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Married: Date of Marriage ___ /___ /___	7b. Chamber/Association 8. Type of coverage you are applying for: ☐ Individual ☐ Family
3. City State County Zip Code	6. Telephone: Home: ( ) – Work: ( ) –	9. Primary language if other than English:

10. MEMBER INFORMATION

Add	Delete	Name: Indicate different last names, if applicable. List oldest dependents first. First M.I. Last	Date of Birth (mm/dd/yy) ***All dependents over age 18 must sign below***	Relationship	Social Security Number	Medicare A & B* Effective Date ****Copy of Medicare Card must be attached.***	Full-Time Student	You, and each dependent, **must** select a **Primary Care Physician (PCP)**. Females may also choose one OB/GYN. For all selections, indicate if you are a current patient and the PCP # from the provider directory. **PCP First and Last Name**	**Office Location**	PCP Number	✓ if current patient
☐	☐	00 Applicant	/ /	Self ☐ M ☐ F		☐ A / / ☐ B / /		PCP OB/GYN			☐ ☐
☐	☐	01	/ /	☐ Husband ☐ Wife ☐ Other		☐ A / / ☐ B / /		PCP OB/GYN			☐ ☐
☐	☐	02	/ /	☐ Son ☐ Daughter		☐ A / / ☐ B / /	☐ Yes ☐ No	PCP OB/GYN			☐ ☐
☐	☐	03	/ /	☐ Son ☐ Daughter		☐ A / / ☐ B / /	☐ Yes ☐ No	PCP OB/GYN			☐ ☐
☐	☐	04	/ /	☐ Son ☐ Daughter		☐ A / / ☐ B / /	☐ Yes ☐ No	PCP OB/GYN			☐ ☐

11. DEPENDENT

Do your dependents reside in your home?

☐ Yes ☐ No If no, give address(es):

Full-time college students age 19 and over: Expected Date of Graduation:

School Name and Address:

Do you have a disabled dependent beyond age 19?

☐ No ☐ Yes (list name[s]):

13. SIGNATURES

AGREEMENT: I have read and agree to the release on the reverse side of this form.

Applicant's Signature Date	Adult Dependent Signature Date
Adult Dependent Signature Date	Adult Dependent Signature Date

12. OTHER INSURANCE

Other Coverage—Do you, your spouse, or any of your dependents have any other medical insurance that will be maintained in addition to CDPHP? ☐ Yes ☐ No If yes, complete below.

Policyholder name:	Relationship: ☐ Self ☐ Spouse ☐ Child	
Social Security Number:	Date of Birth: / /	
Insurance Carrier:	Policy #:	Effective Date:
Address:	Employer Name:	
Covered Individuals:		
Plan Type: ☐ Self Only ☐ Self & Family	Coverage Type: ☐ Hospital ☐ Medical ☐ Drug ☐ Dental ☐ Vision	

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

Form 5315-0901

THIS COPY TO BE RETAINED BY EMPLOYER

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Enrollment Application/ Change Form

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☐ New Enrollment ☐ Name Change ☐ Cobra Continuation ☐ Add Dependent	☐ New Hire ☐ Open Enrollment ☐ Qualifying Event/Reason: ____ ☐ **Effective Date** ____
☐ Termination ☐ Remove Dependent Only	☐ Employee Terminated ☐ Moved Out of Area ☐ Open Enrollment—Transferred to another plan ☐ Dissatisfaction ☐ Cost ☐ Spouse's Coverage ☐ Other: ____ **Effective Date:** ____

EMPLOYER USE

Date hired ___ /___ /___ Date of status change ___ /___ /___
☐ Part- to full-time ☐ Temporary to permanent
☐ Union to non-union ☐ Other ____
Date coverage is to be effective: ____
Group/Division # : __ __ __ __ __ __ __ - __ __ __ __
Employee Status: A. ☐ Full-time ☐ Part-time *(hours per week)* ____
B. ☐ Active ☐ Retiree ☐ Salaried ☐ Union ☐ Other
Group Administrator Initials *(required)* ____

Check Type of Coverage: ☐ **Premier (CDPHP HMO)** ☐ **Plus (CDPHP HMO with UBI POS)** ☐ **Paragon (UBI POS)**

SUBSCRIBER

1. First Name M.I. Last Name
2. Street Address Apt. #
3. City State County Zip Code
4. Your Social Security # ___ ___ ___ – ___ ___ – ___ ___ ___ ___
5. Marital Status: ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Married: Date of Marriage ___/___/___
6. Telephone: Home: ( ) – Work: ( ) –
7a. Employer Name
7b. Chamber/Association
8. Type of coverage you are applying for: ☐ Individual ☐ Family
9. Primary language if other than English:

10. MEMBER INFORMATION

You, and each dependent, **must** select a **Primary Care Physician (PCP)**. Females may also choose one OB/GYN. For all selections, indicate if you are a current patient and the PCP # from the provider directory.

Add	Delete	Name: Indicate different last names, if applicable. List oldest dependents first. First M.I. Last	Date of Birth (mm/dd/yy) ***All dependents over age 18 must sign below***	Relationship	Social Security Number	Medicare A & B* Effective Date ***Copy of Medicare Card must be attached.***	Full-Time Student	**PCP First and Last Name**	**Office Location**	PCP Number	✔ if current patient
☐	☐	00 Applicant	/ /	Self ☐ M ☐ F		☐ A / / ☐ B / /		PCP OB/GYN			☐ ☐
☐	☐	01	/ /	☐ Husband ☐ Wife ☐ Other		☐ A / / ☐ B / /		PCP OB/GYN			☐ ☐
☐	☐	02	/ /	☐ Son ☐ Daughter		☐ A / / ☐ B / /	☐ Yes ☐ No	PCP OB/GYN			☐ ☐
☐	☐	03	/ /	☐ Son ☐ Daughter		☐ A / / ☐ B / /	☐ Yes ☐ No	PCP OB/GYN			☐ ☐
☐	☐	04	/ /	☐ Son ☐ Daughter		☐ A / / ☐ B / /	☐ Yes ☐ No	PCP OB/GYN			☐ ☐

11. DEPENDENT

Do your dependents reside in your home?
☐ Yes ☐ No If no, give address(es):

Full-time college students age 19 and over: Expected Date of Graduation:
School Name and Address:

Do you have a disabled dependent beyond age 19?
☐ No ☐ Yes (list name[s]):

13. SIGNATURES

AGREEMENT: I have read and agree to the release on the reverse side of this form.

Applicant's Signature	Date	Adult Dependent Signature	Date
Adult Dependent Signature	Date	Adult Dependent Signature	Date

12. OTHER INSURANCE

Other Coverage—Do you, your spouse, or any of your dependents have any other medical insurance that will be maintained in addition to CDPHP? ☐ **Yes** ☐ **No If yes, complete below.**

Policyholder name:
Relationship: ☐ Self ☐ Spouse ☐ Child
Social Security Number:
Date of Birth: / /
Insurance Carrier:
Policy #:
Effective Date:
Address:
Employer Name:
Covered Individuals:
Plan Type: ☐ Self Only ☐ Self & Family
Coverage Type: ☐ Hospital ☐ Medical ☐ Drug ☐ Dental ☐ Vision

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

Form 5315-0901

THIS COPY TO BE RETAINED BY EMPLOYEE TO SERVE AS A TEMPORARY ID CARD, SUBJECT TO ELIGIBILITY.

IMPORTANT

Failure to complete any sections will result in a processing delay of your application, member ID cards and claims payment. Failure by your employer to complete the employer section will also result in a delay.

If you should have any questions about this Enrollment Application/Change Form, please call the CDPHP Marketing Department at (518) 641-5000 or 1-800-993-7299. Thank you for choosing CDPHP for your health care coverage.

RELEASE

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.

On behalf of myself and any dependents listed, I hereby apply for coverage under the Master Group Contract issued to my employer by Capital District Physicians' Health Plan, Inc. and/or CDPHP Universal Benefits, Inc.

I understand that the benefits for which I (we) will be eligible are in accordance with those described in the Master Group Contract and any attached riders. I further understand that for HMO benefits provided by Capital District Physicians' Health Plan, Inc., except for emergencies, covered services must be obtained through a participating physician (unless otherwise noted in rider) or in a participating hospital (unless otherwise noted in rider) when admitted or referred by a participating physician (unless otherwise noted in rider), and also that certain services may require a copayment (unless otherwise noted in rider) by me (or my dependents) directly to the provider of such services.

I hereby permit my employer to deduct the necessary Health Services Fees, if any, from my wages or salary, with the understanding that the employer acts as my agent in all dealings with CDPHP, and that all acts performed by the employer and all notices given to the employer in such dealings are binding upon me, as not prohibited by statute or regulation.

I understand that unresolved grievances are subject to the procedure specified in the Master Group Contract.

I hereby permit any person or institution who shall have rendered services to me or to any member of my family unit under any coverage issued by CDPHP, or its related companies, to make available, upon request, to CDPHP (and to any professional or entity assisting CDPHP in providing services, including, but not limited to, managing health care services, administering claims and pursuing proper payment of claims, to me or to any member of my family unit under the Master Group Contract) any photographs, records, or information regarding such services, including any mental health, alcoholism and/or substance abuse treatment records and any confidential HIV related information, to such an extent as may be reasonable to enable CDPHP to provide services under the Master Group Contract. This release to disclose medical information shall remain in effect until revoked by me in writing and may be revoked at any time except to the extent that CDPHP and/or other professionals or entities have already acted in reliance on it. If not previously revoked by me, this release will terminate upon termination of my participation in CDPHP.

I hereby represent to you that all information furnished by me hereon is true and complete to the best of my knowledge.

CDPHP COMPANIES

Capital District Physicians' Health Plan, Inc.; CDPHP Universal Benefits, Inc.