

E. DEPENDENT INFO *Cont'd*

For **HMOs only**, you and each dependent **MUST** select a Primary Care Physician (PCP). Females may also choose one OB/GYN. Also indicate if a member is a current patient and get the Physician # and Office Location from the provider directory or at www.cdphp.com. For all other products, include copy of your HIPAA certificate. If you have Medicare Parts A and B, include a copy of your Medicare card.

8b. Last	First	M.I.	SSN (Required)	Date of Birth	Medical Add or Delete
Rel: <input type="radio"/> Son <input type="radio"/> Daughter <input type="radio"/> Full-time student? <input type="radio"/> Disabled <input type="radio"/> End-Stage Renal Disease <input type="radio"/>					
Medicare number: _____ Part A effective date: _____ Part B effective date: _____ Delta Dental Add or Delete					
Primary Language: Spoken: _____ Written: _____ Delta Dental Add or Delete					
Ethnicity: <input type="radio"/> White <input type="radio"/> Black <input type="radio"/> American Indian/Alaska Native <input type="radio"/> Asian/Pacific Islander <input type="radio"/> Hispanic/Latino <input type="radio"/> Other <input type="radio"/>					
School name (if student) _____ Expected date of graduation _____ School address (City, State, ZIP) _____					
Previous coverage: <input type="radio"/> Yes Previous carrier: _____ Effective from: _____ To: _____					
HMO only—Physician (PCP) Last	First	M.I.	Office location	Phys #	Current Patient?
_____					<input type="radio"/>
OB/GYN Last	First	M.I.	Office location	Phys #	Current Patient?
_____					<input type="radio"/>

8c. Last	First	M.I.	SSN (Required)	Date of Birth	Medical Add or Delete
Rel: <input type="radio"/> Son <input type="radio"/> Daughter <input type="radio"/> Full-time student? <input type="radio"/> Disabled <input type="radio"/> End-Stage Renal Disease <input type="radio"/>					
Medicare number: _____ Part A effective date: _____ Part B effective date: _____ Delta Dental Add or Delete					
Primary Language: Spoken: _____ Written: _____ Delta Dental Add or Delete					
Ethnicity: <input type="radio"/> White <input type="radio"/> Black <input type="radio"/> American Indian/Alaska Native <input type="radio"/> Asian/Pacific Islander <input type="radio"/> Hispanic/Latino <input type="radio"/> Other <input type="radio"/>					
School name (if student) _____ Expected date of graduation _____ School address (City, State, ZIP) _____					
Previous coverage: <input type="radio"/> Yes Previous carrier: _____ Effective from: _____ To: _____					
HMO only—Physician (PCP) Last	First	M.I.	Office location	Phys #	Current Patient?
_____					<input type="radio"/>
OB/GYN Last	First	M.I.	Office location	Phys #	Current Patient?
_____					<input type="radio"/>

8d. Last	First	M.I.	SSN (Required)	Date of Birth	Medical Add or Delete
Rel: <input type="radio"/> Son <input type="radio"/> Daughter <input type="radio"/> Full-time student? <input type="radio"/> Disabled <input type="radio"/> End-Stage Renal Disease <input type="radio"/>					
Medicare number: _____ Part A effective date: _____ Part B effective date: _____ Delta Dental Add or Delete					
Primary Language: Spoken: _____ Written: _____ Delta Dental Add or Delete					
Ethnicity: <input type="radio"/> White <input type="radio"/> Black <input type="radio"/> American Indian/Alaska Native <input type="radio"/> Asian/Pacific Islander <input type="radio"/> Hispanic/Latino <input type="radio"/> Other <input type="radio"/>					
School name (if student) _____ Expected date of graduation _____ School address (City, State, ZIP) _____					
Previous coverage: <input type="radio"/> Yes Previous carrier: _____ Effective from: _____ To: _____					
HMO only—Physician (PCP) Last	First	M.I.	Office location	Phys #	Current Patient?
_____					<input type="radio"/>
OB/GYN Last	First	M.I.	Office location	Phys #	Current Patient?
_____					<input type="radio"/>

F. OTHER INSURANCE

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

9. Policyholder name	Policy #	Insurance carrier	Employer name

Date of birth: _____	Address: _____		
Effective date: _____	Coverage type:	<input type="radio"/> Hospital <input type="radio"/> Medical <input type="radio"/> Drug <input type="radio"/> Dental <input type="radio"/> Vision	
Covered Individuals—Check all that apply	<input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Dependents		

Note: Make sure you sign and date the application on the next page.

G. SIGNATURE: AGREEMENT: I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge and that I have read the important information on the last page of this form.

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 \$5,000 and the stated value of the claim for each such violation.

10. Applicant's Signature: _____

11. Date: _____

IMPORTANT INFORMATION

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® member services department at (518) 641-3700 or 1-800-777-2273. Thank you for choosing CDPHP for your health care coverage.

Your signature on this application hereby affirms the following:

On behalf of myself and any dependents listed, I hereby apply for coverage under the Master Group Contract (health and/or dental, as the case may be) issued to my employer by Capital District Physicians' Health Plan, Inc. and/or CDPHP Universal Benefits® Inc. (CDPHP UBI) and/or Delta Dental of New York, 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/or Delta Dental of New York, Inc., 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.

Note: CDPHP UBI coverage may have a pre-existing condition clause. Please consult your benefit materials or check with your personnel office for more specific information.

CDPHP COMPANIES

Capital District Physicians' Health Plan, Inc.
CDPHP Universal Benefits® Inc.
Capital District Physicians' Healthcare Network, Inc.

Delta Dental Service Plans are underwritten and administered by Delta Dental of New York, Inc.



Delta Dental of New York
One Delta Drive
Mechanicsburg, PA 17055
1-800-932-0783
TTY/TDD 1-888-373-3582
www.deltadentalins.com