PO BOX 710
Williamsville, NY 14231-0710
independenthealth.com

Chamber of Commerce and Professional Association

Chamber/Association Initials ***REQUIRED FOR PROCESSING***

Initials ________

Today's Date ________

1. **Please check one:** ☐ GROUP ENROLLMENT APPLICATION ☐ CHANGE FORM ☐ COBRA ELECTION
2. **EFFECTIVE DATE** ____ / ____ / ____ (Add, Change or Cancellation) **GROUP #** ________ **PLAN #** ________ (Please Reference Benefit Summary)

Change Only / Please check all that apply:
☐ PLAN CHANGE ☐ PHYSICIAN CHANGE
☐ NAME CHANGE ☐ ADDRESS CHANGE
☐ ADD DEPENDENT / QUALIFYING EVENT (birth, marriage, etc.) ________

Reason codes on reverse side:
☐ CANCEL POLICY / Reason code ________
☐ REMOVE DEPENDENT / Reason code ________
DEPENDENDT ID # ________

3. PLEASE PRINT AND RETURN TO YOUR EMPLOYER UPON COMPLETION. THANK YOU FOR CHOOSING INDEPENDENT HEALTH.

APPLICANT'S LAST NAME | FIRST NAME | MI

ADDRESS (NUMBER, STREET, APARTMENT)

CITY | COUNTY | STATE | ZIP + 4

TELEPHONE
HOME ( ) - WORK ( ) - EMAIL

HAVE YOU EVER BEEN A MEMBER OF INDEPENDENT HEALTH?
☐ YES If yes, list your identification number
☐ NO

PRIOR HEALTH INSURANCE: *Prior coverage for previous 12 months:*
COVERAGE DATE(S)
FROM: ________ TO: ________
(Please provide detail on reverse side.)

WHAT IS YOUR PRIMARY LANGUAGE? | GENDER ☐ MALE ☐ FEMALE

8. EMPLOYER ATTESTATION (employer must complete this section)

CHAMBER OR ASSOCIATION

EMPLOYER NAME

EMPLOYER ADDRESS

CITY | COUNTY | STATE | ZIP + 4

EMPLOYER TELEPHONE | EMPLOYER TAX ID

DATE JOINED CHAMBER/ASSOCIATION | DATE OF EMPLOYMENT

IS APPLICANT CURRENTLY WORKING AT LEAST 17.5 HOURS/WEEK? ☐ Yes ☐ No | WAS APPLICANT GIVEN A CHOICE OF HEALTH PLANS? ☐ Yes ☐ No

EMPLOYER SIGNATURE | DATE

4. Member Information:

LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATION-SHIP	IH PHYSICIAN NUMBER (or full name and address)	CURRENT PATIENT YES	CURRENT PATIENT NO	IH USE ONLY PHYSICIAN NUMBER
APPLICANT					SELF Code * ☐	Primary / OB/GYN			
SPOUSE					☐ HUSBAND ☐ WIFE Code * ☐	Primary / OB/GYN			
CHILD					☐ Daughter ☐ Son Code * ☐	Primary / OB/GYN			
CHILD					☐ Daughter ☐ Son Code * ☐	Primary / OB/GYN			
CHILD					☐ Daughter ☐ Son Code * ☐	Primary / OB/GYN			

* Please identify parent / child relationship (if applicable): A† - Adopted (within last 18 months) P† - Adoption in Process S - Stepchild H - Handicapped D - Disabled L - Legal Guardianship G - Grandchild † Please attach Adoption/Adoption in Process papers

5. While enrolled in Independent Health, will you or your dependent(s) be covered by any of the following: If additional space is required, please attach a separate sheet.

CHECK **YES** OR **NO**:

• MEDICARE ☐ Yes **(Please list all covered members)** ☐ No — LAST NAME | FIRST | MI | ID NO. | PART A EFF. DATE | PART B EFF. DATE

• OTHER HEALTH INSURANCE* ☐ Yes (Please list all covered members) ☐ No — LAST NAME OF **POLICY HOLDER** | FIRST | MI | INSURANCE NAME | PHONE NO.

*Including no fault and/or workers' compensation (in the event of an injury).

6. Is your child (or children) a full-time college student? ☐ Yes ☐ No
If yes, please complete section on back of application.

7. AUTHORIZATION: I have read and agree to the authorization on the reverse side of this form.

ALL SECTIONS MUST BE COMPLETED BEFORE PROCESSING. **SUBSCRIBER'S SIGNATURE:** ________ DATE: ________

IH USE ONLY	Effective Date	Pre Ex	Group Number	Account Number	Tier Code	Benefit Package Code

OA-6432-4603L-REV0907

REASON CODES:

- **B.** Dependent Reached Age 23/24/25
- **C.** Group Cancel - Open Enrollment
- **D.** Deceased
- **G.** Group Cancel - Mid-contract
- **I.** Transferring to Another Group
- **L.** Layoff
- **M.** Moved out of Area
- **N.** Nonpayment
- **O.** Member Cancel - Open Enrollment
- **P.** Personal Reasons
- **R.** Retired
- **T.** Terminated Employment
- **U.** Dependent Age Cut-off (age 19)
- **V.** Medicare
- **W.** Now Under Spouse's Plan
- **X.** No Longer Eligible
- **Y.** Dissatisfaction with the Plan
- **Z.** Dependent Age Cut-off - Waiver Required

ELIGIBILITY FOR STUDENT COVERAGE

(applies only to those members whose contract includes an age extension rider)

Your contract may require that a dependent age 19 or above maintain full-time student status (a minimum of 12 credit hours) at an accredited college or university to remain eligible as a dependent on your contract.

Please check the statement that best describes your child's student status:

☐ **Yes, my child is a full-time college student** as defined above.
Following is information that may be verified:

Child	College or University	Student ID No.
Address	City, State, Zip Code	Expected Date of Graduation
Child	College or University	Student ID No.
Address	City, State, Zip Code	Expected Date of Graduation

(Please attach separate sheet if you have additional children who are eligible full-time students)

☐ **Yes, my child is a full-time college student but is currently on medical leave.** Please attach a note from your physician verifying your child's condition.

☐ **No, my child is not a full-time college student.** Please send me information on a direct pay policy.

PRIOR HEALTH INSURANCE (CONTINUED)

HEALTH INSURANCE COMPANY (include address and phone number of previous carrier)	ID #	COVERAGE FROM MONTH/YEAR	COVERAGE TO MONTH/YEAR

CERTIFICATION & CONSENT

I certify that the information given on this application is current, true and correct to the best of my knowledge and I have read and agree to this statement. This application cannot be processed if birth date(s) and Social Security Number(s) are not completed. I understand that 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 be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

I understand that this application and my, my spouse or eligible dependent's subsequent receipt of health care services are subject to the terms of the applicable coverage document. I understand that if I enroll in a health coverage product through my employer, my employer is responsible for remitting premium payments on my behalf, or in the case of self-insured employers, my employer is responsible for remitting claims payments to us.[1]

I consent to any person or institution who shall have rendered health services to me or to any member of my family under the applicable coverage document to make available any photographs, records or information regarding such services to us. Any information received or generated by us shall be kept confidential and secure as required by applicable law. I also consent to you disclosing my health information or the health information of any member of my family, as permitted by applicable law, for your own or another provider, health plan, health care clearinghouse or other covered entity's treatment, payment or health care operations. This consent shall remain in effect until revoked by me in writing.

I acknowledge that if I am presently without coverage for longer than sixty-three (63) days, then a pre-existing condition waiting period may apply. Pre-existing condition waiting periods apply to individuals with conditions diagnosed or recommended for treatment within six (6) months prior to the enrollment date of new coverage and shall not exceed twelve (12) months following this date.

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[1] The terms "You" and/or "Us" means Independent Health Association, Inc. or Independent Health Benefits Corporation for members who enroll in a health coverage product through their employers or individually. For members whose employers self-insure their health coverage, the terms "You" and/or "Us" means Independent Health Corporation, a third-party administration company.