

**Commercial and Direct**

Enrollment Form     Change Form



One Huntington Quadrangle, Suite 4C01 • Melville, NY 11747

Phone: 1-800-707-MDNY • Fax 631-454-1915

A. APPLICANT INFORMATION																																								
Name (Last) _____ (First) _____ (MI) _____			Home Phone ( ) _____		Work Phone ( ) _____		Soc. Sec. # _____																																	
Date Of Hire _____		Mailing Address _____			City _____		County _____		State _____ Zip _____																															
B. OTHER INSURANCE																																								
Do you or any of your dependents have coverage under any other medical plan? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, provide the information below:																																								
Name of the Insured _____			Employer Name _____			Telephone _____		<input type="checkbox"/> Individual Coverage <input type="checkbox"/> Family Coverage																																
Insurance Company Name _____					Are You or any of your dependents eligible for Medicare or Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No																																			
Were you covered by another medical/hospital plan within the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, provide the information in section F																																								
C. TYPE OF COVERAGE (Select one)						D. STATUS CHANGE																																		
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td></td> <td style="text-align: center;">5</td> <td style="text-align: center;">10</td> <td style="text-align: center;">15</td> <td style="text-align: center;">20</td> <td style="text-align: center;">25/40</td> </tr> <tr> <td>HMO</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>POS</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Direct HMO</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Direct POS</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>							5	10	15	20	25/40	HMO						POS						Direct HMO						Direct POS						<input type="checkbox"/> Add Dependent <input type="checkbox"/> Remove Dependent <input type="checkbox"/> Address Change <input type="checkbox"/> Name Change <input type="checkbox"/> Reinstatement <input type="checkbox"/> PCP Change <input type="checkbox"/> Conversion (Direct Pay) <input type="checkbox"/> Termination Date _____ <input type="checkbox"/> Reason _____				
	5	10	15	20	25/40																																			
HMO																																								
POS																																								
Direct HMO																																								
Direct POS																																								
E. EMPLOYER INFORMATION (If Applicable)																																								
Employer Name _____					Telephone _____			Is Employee currently working at least 20 hours per week? <input type="checkbox"/> Yes <input type="checkbox"/> No																																
Group Number _____					Billing Account Number _____																																			
F. ENROLLMENT INFORMATION																																								
Name (*Indicate if last name is different) (Last Name)    (First)    (MI)	Birth Date Mo / Day / Yr			Social Security Number	Sex	Relationship Code (1)	Full-Time Student (Y/N)	* Former Health Insurance Coverage (Previous 12 Months)	* Date of Former Coverage (From-To)	Primary Care Physician ID# or Name (See Provider Directory)	Current Patient (Y/N)																													
Applicant						001																																		
Spouse																																								
Dependent																																								
Dependent																																								
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(1) Relationship Codes    Applicant=001    Spouse=002    Child=003    *Student=004    *Disabled=005    *Stepchild=006    *Legal Guardianship=007    *=Documentation Required																																								
G. EMPLOYEE / APPLICANT SIGNATURE (Please read this information in the following section carefully and then sign and date this form.)																																								
• I hereby apply for the MDNY Healthcare, Inc. (MDNY) benefit plan selected. I acknowledge that I understand all the benefits and coverage as specified in the enrollment materials and agree to abide by all the rules and regulations therein specified. • I certify that I work a minimum of 20 hours per week. (Commercial Only) • I certify that I elect to enroll myself and the family members (dependents) indicated on this form with MDNY. I certify that all dependents listed on this form are eligible for benefits and coverage under the terms of the MDNY subscriber agreement. I acknowledge that I understand that MDNY has no liability to provide benefit and coverage for ineligible dependents. • I acknowledge that I understand that if I have a new dependent as a result of a marriage, birth or adoption, that I must provide appropriate documentation to enroll that new dependent within 30 days after the qualifying event. • I acknowledge that I understand that pre-existing conditions will not be covered during the first 12 months of the contractual coverage with MDNY. I further understand, however, that MDNY will reduce the pre-existing limitation if 1) I provide MDNY with a certificate of coverage identifying substantially similar health insurance coverage that I/we had before my MDNY coverage effective date and 2) such coverage did not have a gap of more than 63 days. The pre-existing condition limitation will be reduced by the amount of time covered by the previous policy. A pre-existing condition is a condition for which medical advice, diagnosis, care or treatment was recommended or received during 6 months preceding my MDNY coverage effective date, excluding pregnancy, except the pregnancy of an individual						Direct Pay enrollee may be excluded for a maximum of ten (10) months, subject to a credit for previous credible coverage. • MDNY Healthcare, Inc. (including its affiliates and authorized agents, collectively "MDNY Healthcare") and participating network providers require access to member medical information for a number of purposes. Accordingly, I authorize the sharing of member medical information about myself and my dependents between MDNY Healthcare and any hospital, physician, or other health care provider or health care delivery system as MDNY Healthcare and such participating providers may require. (I am assured that it is MDNY Healthcare's policy to protect the confidentiality of my confidential medical information to the full extent required by law). I know that I, as an individual entitled to act on my behalf, am entitled to receive a copy of this authorization upon request and agree that a photocopy is as valid as the original. • If I am required to contribute to the premium for my coverage, I hereby authorize my employer to deduct such contributions in advance from wages due me and remit same to MDNY. • Any person who knowingly and with the 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 a fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to civil penalty not to exceed \$5000, and the stated value of the claim for each violation.																																		
• I have carefully read this section and certify that all information on this form is true and complete.						Employee/Applicant Signature _____ Date _____																																		
H. EMPLOYER AUTHORIZATION (IF APPLICABLE)																																								
By signing this form, I verify that to the best of my knowledge, the information contained herein is true and complete. I certify that the person is an eligible employee and works for the employer identified on this form. I certify that any dependent(s) listed on this form are eligible for coverage.																																								
Signature – Authorized Company Representative _____						Print Name / Title _____ Date _____																																		