EMPLOYEE ENROLLMENT FORM

(Please print & complete in full to avoid any delays)

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New York, NY 10006
Tel: (212) 747-0877
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PLAN OPTION:	☐ HMO ☐ POS ☐ HNY	TYPE OF COVERAGE:	☐ SINGLE ☐ COUPLE ☐ PARENT/CHILD ☐ FAMILY

EMPLOYEE INFORMATION

Last Name	First Name	MI	Date Of Birth	Sex ☐ M ☐ F

Social Security Number	Email Address

Home Address	Apt. No.	City	State	Zip Code

Primary Phone Number	Alternate Phone	Primary Care Physician Name & ID	If married, date of marriage:

Name of Employer	Business Phone

TYPE OF ACTIVITY

☐ New Subscriber ☐ Change of Plan or Primary Care Physician ☐ Termination

☐ Add / Remove Spouse, Dependent Child Reason: _____ Date: _____

DEPENDENT INFORMATION (Please use another enrollment form if you have more dependents)

	Add / Remove	Last Name, First Name, MI	Sex	Date of Birth	Social Security	Primary Care Physician Name & ID
SUBSCRIBER	☐ / ☐			/ /		
SPOUSE	☐ / ☐			/ /		
CHILD 1.	☐ / ☐			/ /		
CHILD 2.	☐ / ☐			/ /		
CHILD 3.	☐ / ☐			/ /		
CHILD 4.	☐ / ☐			/ /		

STUDENT INFORMATION

If dependent children listed are age 19 or older, do they attend school on a full-time basis? Yes ☐ No ☐	If yes, list first name of child and school	Is any dependent disabled? Yes ☐ No ☐	If yes, list first name of child

OTHER INSURANCE INFORMATION

Do you, your spouse or dependent children have other Health Insurance? Yes ☐ No ☐	Name of Insured	Name of Insurance carrier & Policy No.

Give Name of Prior Insurer and Date of Termination	Proof of Prior Coverage

EMPLOYER INFORMATION

Name of Group	Group Number	Contract Plan

Employment Hire Date	Enrollment Effective Date	Date Submitted to AHP	Approved by (employer representative signature):

Is employee active at work? ☐ Yes ☐ No Hours worked per week _____	Move coverage to COBRA: ☐ Yes ☐ No	Qualifying event: _____ Qualifying date: _____

I authorize deductions from my earnings for any required contributions. I authorize all health professionals to provide Easy Choice Health Plan of New York and its contracted professionals, information about health (including mental illness) care advice, treatment or supplies provided to me or my dependents relating to coverage for the purpose of coordinating patient care, evaluating and administering claims for benefits, and for fulfilling Easy Choice Health Plan of New York's obligations under state and federal law. I will discuss any questions concerning the plan with Easy Choice Health Plan of New York 's member services. My signature below affirms eligibility for coverage, and all that information provided is full, complete and true to the best of my knowledge.

I understand that any person who knowingly with intent to defraud any insurance 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 material fact thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed $5,000 and that stated value of the claim for each such violation.

In the absence of creditable coverage Pre-existing Medical Conditions may not be covered for 11 months from the initial enrollment date.

EMPLOYEE/APPLICANT SIGNATURE: X _____ DATE: _____

"Easy Choice Health Plan of New York" is a marketing name for Atlantis Health Plan, Inc.