HMO Enrollment Form for NYS Employees

AW3-3U

PERSONNEL OFFICE ONLY

☐ PS404

Coverage effective: _____

Signature: _____

Date Mailed: _____

Agency Code and Name ☐☐☐☐☐

_____

Negotiating Unit Code ☐☐

HOW TO COMPLETE THIS APPLICATION

1. Information on this form is not official without a completed NYS Health Insurance Transaction Form (PS404).
2. Use dark ink. Press firmly so that all three copies are clear.
3. This form must be submitted, together with the PS404, to your agency Health Benefits Administrator.
4. All applicants MUST complete Sections 1 and 2 and in addition Sections 3, 4 and 5 must be completed, if they apply to you.
5. Please sign form in the space indicated below.

SECTION 1: Enrollee Information

YOUR LAST NAME | FIRST | M.I. | Date of Birth

ADDRESS (STREET NO.) | CITY | STATE | ZIP

SOCIAL SECURITY NO. | ☐ MALE ☐ FEMALE | ☐ SINGLE ☐ MARRIED | ☐ WIDOWED ☐ DIVORCED

TELEPHONE NO. (Home) (____)_____ (Work) (____)_____ NEG. UNIT NAME _____

SECTION 2: Enrollment Information

Name of HMO _____ NYS HMO Code ☐☐☐

☐ Individual Coverage ☐ Family Coverage

Have you or any dependent ever been a member of this HMO before? ☐ Yes ☐ No

If yes, through what employer: _____

Subscriber's name: _____ ☐ Self ☐ Spouse ☐ Other (relationship)

In this section, depending upon the HMO you join, you must enter, for yourself and each dependent, the name and number (if any) of the health center, medical group or primary care physician selected. **This section must be completed before you receive your ID Cards.**

	Health Center, Medical Group or Primary Care Physician Name and Number	Check if Current Patient	OB/GYN Name Pharmacy Name (if applicable)	HMO Use Only
ENROLLEE				
SPOUSE				

SECTION 3: Spouse/Domestic Partner Information

LAST NAME (if different) | FIRST | M.I. | Date of Birth

ADDRESS (if different) | CITY | STATE | ZIP

SOCIAL SECURITY NO. | Employed: ☐ Yes ☐ No

If yes, employer's name and address: | Health Insurance Company (if different from yours)

SECTION 4: Dependent Information

			Date of Birth	Relationship	Health Center, Medical Group or Primary Physician Name and Number	Check if Current Patient	OB/GYN Name Pharmacy Name (if applicable)	HMO Use Only
DEPENDENT LAST NAME (if different)	FIRST	M.I.		☐ Son ☐ Daughter				
DEPENDENT LAST NAME (if different)	FIRST	M.I.		☐ Son ☐ Daughter				
DEPENDENT LAST NAME (if different)	FIRST	M.I.		☐ Son ☐ Daughter				
DEPENDENT LAST NAME (if different)	FIRST	M.I.		☐ Son ☐ Daughter				
DEPENDENT LAST NAME (if different)	FIRST	M.I.		☐ Son ☐ Daughter				

SECTION 5: Medicare Information

If you are enrolled in Medicare, please check the appropriate boxes.

☐ Part A (Hospital) Effective date: You _____ Spouse_____ Dependent (Name & Date)_____

☐ Part B (Medical) Effective date: You _____ Spouse_____ Dependent (Name & Date)_____

THINGS YOU SHOULD KNOW: Please read carefully.

1. I certify that the statements made are true and complete to the best of my knowledge and belief, and that I am familiar with my contract with the HMO that I am selecting, and that I agree to abide by the terms therein.
2. I authorize any licensed physician, hospital or other health care provider to furnish my HMO with such medical information about myself and eligible dependents listed on the application that may be required, and I understand and agree that (with the exception of emergency procedures) all services, in order to be covered by my HMO, must be performed either by a Participating Physician or authorized by prior referral from a Primary Care Physician.
3. I agree to pay directly to providers of health care such co-payments as are required.

Signature: _____ **Date:** _____

PLEASE RETURN THIS COMPLETED APPLICATION TO YOUR AGENCY HEALTH BENEFITS ADMINISTRATOR

WHITE COPY – HMO YELLOW COPY – AGENCY PINK COPY – ENROLLEE