introhealth plus

Enrollment Worksheet

Properly submitted enrollment materials help avoid plan activation delays. Here's a checklist to help you properly assemble, complete, and submit your application and first payment:

1 **Complete the Worksheet items in the areas below** (obtain monthly rates from the GHI Hospital-Only Open Enrollment Monthly Rate sheet and the Limited Benefit Coverage NYS Monthly Rates sheet).

2 **Complete, sign, and date the GHI Non-Group Application for Individuals Not Eligible for Medicare application.**

3 **Complete, sign, and date the IntroHealthPlus Health Essential Enrollment Form application.**

4 **Return the TOTAL INITIAL PAYMENT payable to Conference Associates, Inc., to either your agent or broker or to:**

CAI/NYSBG, 180 East Main Street, Suite 205, Patchogue, NY 11772

Fill Out Your Contact Information:

Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone:_____ Email:_____

☐ Check here if you would like to receive plan information & communications via e-mail. (Be sure to include your e-mail).

Insurance Agent Information (where applicable):

Agent Name:_____

Agency Name:_____

Phone:_____ Email:_____

Check Plan Type:

☐ Individual
☐ 2-Party
☐ Family

Check Region:

☐ Downstate
☐ Mid-Hudson
☐ Albany
☐ Syracuse
☐ Rochester
☐ Utica/Watertown
☐ Buffalo

Initial Payment Calculation:

GHI Rate
From the GHI Hospital-Only Open Enrollment Monthly Rate sheet: $_____

Limited Medical Indemnity Coverage Cost
From the Limited Medical Indemnity NYS Monthly Rate sheet: $_____

NYSBG Monthly Membership/Admin Fee: $ 12.50

Total Monthly Cost: $_____

One-Time Enrollment Fee applies to initial enrollment: $ 25.00

TOTAL INITIAL PAYMENT due with enrollment materials: $_____

NON-GROUP APPLICATION FOR INDIVIDUALS NOT ELIGIBLE FOR MEDICARE

(OPEN ENROLLMENT PLAN)

INSTRUCTIONS

- Please type or print firmly with ballpoint pen.
- This is an application for hospital coverage or hospital/medical coverage. It may be used to apply for new enrollment, or to change your type of contract. Complete this application if you or your spouse, or both, are not eligible for Medicare due to age. Your contract should be appropriate (Individual or Family) to your status as indicated below:
  - Individual - If you are unmarried, widowed, divorced, or legally separated and have no dependent children.
    If you are married without dependent children, and your spouse is eligible for Medicare.
  - Family - If you are married, or if you are married with dependent children. If you are married and your spouse is eligible for Medicare, and you have one or more unmarried children under age 19, you should apply for a Family contract for you and your child(ren). Your Medicare-eligible spouse should apply for separate coverage using a Non-Group Medicare Supplement Insurance Application Form.
    - If you are unmarried, widowed, divorced, or legally separated with one or more dependent children.
    - If you have one or more unmarried dependent children under 19 years of age or unmarried, dependent full-time students under 23 years, complete only one application for Family coverage for yourself and your children.
- Please do not submit payment with this application. When the application is processed, a bill will be sent to you. You will also receive your contract(s), as well as a copy of your processed application, in a separate mailing. Your identification card will be sent to you after GHI receives your payment.
- All applicants must:
  a. Complete, sign, and date the application where indicated.
  b. Check the appropriate boxes for type of coverage and type of contract.
  c. Return the completed application to:
     GHI
     P.O. Box 969
     Patchogue, NY 11772

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 five thousand dollars and the stated value of the claim for each such violation.

PRINT IN INK

1. Please complete the following information for the applicant

Full Name of Applicant	Sex ❒ Male ❒ Female	Date of Birth (M/D/Y)	Social Security Number
Home Address (P.O. Box is not acceptable)		Telephone Numbers Work:	Home: Fax:
City	County	State	Zip Code
Mailing Address (If different from Home Address)			
City	County	State	Zip Code
Applicant Email Address	Primary Language Spoken		Race/Ethnicity (See Codes Below)

2. Please complete the following spouse information

Full Name of Spouse	Sex ❒ Male ❒ Female	Date of Birth (M/D/Y)	Social Security Number
Home Address (P.O. Box not Acceptable)		Telephone Numbers Work:	Home: Fax:
City	County	State	Zip Code
Mailing Address (If different from Home Address)			
City	County	State	Zip Code
Spouse Email Address	Primary Language Spoken		Race/Ethnicity (See Codes Below)

3. Please provide the following information for your current or prior health benefits plan.

Type of Plan	Name and Address of Insurer	Telephone Number of Insurer	Name of Policyholder	Policy I.D. Number	Effective Date of Prior Policy	Termination Date of Prior Policy
Hospital		( )				
Medical		( )				

4. Do you intend to replace an existing accident and health insurance policy or coverage with the GHI Program you are now applying for?
❒ No ❒ Yes **If yes, termination date of your other insurance / / . If yes, please check the type of plan you intend to replace. ❒ Hospital Insurance ❒ Medical Insurance Other (Please specify)** _____

5. Is there a waiting period for pre-existing conditions under your existing plan? ❒ No ❒ Yes
If yes, please indicate the effective date of your existing plan. / / .

6. Please complete the information below for each unmarried dependent child under 19 years of age to be covered under the GHI Program. An unmarried dependent child will be covered until December 31 of the year he/she becomes 19.

Dependent Last Name	First Name	M.I.	DOB M/D/Y	Social Security Number	Sex	Relation-ship	Mailing Address (If different from above)	Race/ Ethnicity (See Codes below)	Email Address	Telephone (Daytime)

Race/Ethnicity Codes: (Optional) See explanation on reverse side

A = Asian
B = Black or African American
C = Caucasian
O = Other
I = Native American or Alaskan Native
P = Native Hawaiian or Other Pacific Islander
H = Hispanic or Latino

7. **Please complete the information below for each unmarried dependent child between 19 and 23 years of age who is a full-time student in an accredited educational institution and who is to be covered under the GHI Program. Under programs that cover unmarried dependent students, a dependent student will be covered until December 31 of the year he/she becomes 23 or until he/she otherwise ceases to be an unmarried dependent student.**

Dependent Last Name	First Name	M.I.	D`OB M/D/Y	Social Security Number	Sex	Relation-ship	Mailing Address (If different from above)	Race/ Ethnicity (See reverse side)	Email Address	Telephone (Daytime)	Name and Address of School	Date of Graduation

8. **a. Are you eligible for group coverage that is comparable to the GHI coverage you are applying for in this application?** ❒ No ❒ Yes
Please explain: _____

b. Have you been refused coverage under an employer health plan due to your age, sex, health status or occupation? ❒ No ❒ Yes
Please explain: _____

9. **Has your health insurance coverage been terminated within the last 12 months due to nonpayment of premiums?** ❒ No ❒ Yes

PLEASE READ THE BENEFIT DESCRIPTION OF EACH GHI OPEN ENROLLMENT PROGRAM OPTION IN THE GHI OPEN ENROLLMENT BROCHURE BEFORE MAKING YOUR SELECTION.

10. **If you are a new applicant, or if you wish to add or change hospital coverage or hospital/medical coverage, please check the appropriate box below for the TYPE OF CONTRACT and TYPE OF COVERAGE requested. (The TYPE OF CONTRACT selected must be in accordance with your marital status, as outlined in the instructions at the top of the previous page.)**

I am applying for (please check one box from each column): **SEE ATTACHED SHEET FOR APPLICABLE RATES.**

Column A	**Column B**
❒ Individual	❒ Value Option (365-Day Hospital Program and Medical Program)
❒ Family	❒ 365-Day Hospital Only Program

If you are applying for individual coverage, and if your spouse is eligible for Medicare, check here. ❒

11.

If you are presently enrolled under a GHI Direct Payment Hospital Program, please check the appropriate box below.	**If you are presently enrolled under a GHI Direct Payment Hospital/Medical Program, check the appropriate box below.**
❒ I wish to retain my present hospital coverage.	❒ I wish to retain my present hospital/medical coverage.
❒ I wish to change my present coverage from Individual to Family.	❒ I wish to change my present coverage from Individual to Family.
❒ I wish to change my present coverage from Family to Individual	❒ I wish to change my present coverage from Family to Individual

12. When your application is processed, a bill will be sent to you with your contract(s).

THERE WILL BE AN 11-MONTH WAITING PERIOD FOR BENEFITS FOR ANY CONDITION FOR WHICH MEDICAL ADVICE, DIAGNOSIS CARE OR TREATMENT WAS RECOMMENDED OR RECEIVED DURING THE SIX MONTH PERIOD ENDING ON THE ENROLLMENT DATE OF COVERAGE. THIS WAITING PERIOD WILL BE REDUCED TO THE EXTENT THAT YOU ARE ENTITLED BY LAW TO A CREDIT FOR PRIOR CONTINUOUS CREDITABLE HEALTH COVERAGE.

IF YOUR CONTRACT IS TERMINATED BECAUSE YOU DID NOT PAY PREMIUMS, YOU CANNOT PURCHASE HEALTH INSURANCE FROM GHI FOR 12 MONTHS AFTER THE DATE OF TERMINATION.

I hereby apply for coverage of the type checked above. If this application is for a family contract, I have provided the names of my spouse, unmarried dependent children under 19 years of age (or who become 19 in this calendar year), and unmarried full-time student dependent children under age 23. I make this application on their behalf as well as my own. When the application is processed, coverage will be effective only if payment of the subscription charges is received in accordance with the invoice. I represent and understand that:

A. On my enrollment date, my existing contract(s), if any, will be canceled. Any remaining waiting period for pre-existing conditions under my existing contract will apply to the GHI contract for the same type of coverage. If I am currently covered under an individual contract and wish to change to a family contract for the same type of coverage, my enrollment date in the individual contract will be used to calculate my waiting period for pre-existing conditions. The waiting period for newly covered family members will be calculated from their enrollment date in the family contract. If I am currently covered under a family contract, and wish to change to an individual contract for the same coverage because of divorce, legal separation, annulment or death, my enrollment date in the family contract will be used to compute my waiting period for pre-existing conditions.

B. All statements and answers in this application are true to the best of my knowledge and belief. This application will be made part of my contract(s).

NOTE: BEFORE DATING AND SIGNING THIS APPLICATION, PLEASE MAKE SURE YOU HAVE ANSWERED ALL THE QUESTIONS. ALSO, BE SURE YOU HAVE CHECKED THE APPROPRIATE BOX FOR TYPE OF COVERAGE YOU DESIRE.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim concerning any materially false information, or conceals for the purposes 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 five thousand dollars and the stated value of the claim for each such violation

Applicant's Signature (Do Not Print) Date Signed

Applicant's Spouse's Signature (Do Not Print) Necessary Only When Applying For Family Coverage Date Signed

Why We Ask You for Race/Ethnicity Information

National studies show that differences in access to health care occur along ethnic lines. In our effort to ensure that everyone we serve receives appropriate care, GHI, along with other health insurers, is collecting data on ethnicity with the goal of improving access to care and outcomes for groups who often have poorer results and to improve customer service. Information will only be used by our Medical Department to improve access to needed care and will not be available to any other staff. Answering this question is voluntary.

GHI Web Site

For fast, convenient access to the latest claim status, eligibility, and benefits information, visit GHI's secure Web site at www.ghi.com. Available around the clock, the site offers provider listings, enables you to order ID cards, view an online Explanation of Benefits, access wellness information, and much more.

Translation Services

If English is not your primary language and translation services are needed when calling GHI Customer Service, a representative can help you.

(For GHI Office Use Only)

	(Initials)	(Initials)
Date Application Issued	_____	_____
Date Application Received	_____	_____
Date Application Processed	_____	_____
Date, Contract and Copy of Application Sent	_____	_____
Type of Plan	_____	_____
Group Number	_____	_____
Category Number	_____	_____
Effective Date	_____	_____

introhealth plus®

HEALTH ESSENTIAL ENROLLMENT FORM

Insured Benefits are Underwritten By: United States Fire Insurance Company

(CAI - New York)

A. PLEASE COMPLETE THE FOLLOWING INFORMATION ABOUT YOURSELF, SIGN AND DATE WHERE REQUIRED:

Applicant Name: _____ Sex (M or F): _____ Age: _____ Date of Birth: _____/_____/_____

Address _____ City: _____ State: _____ Zip: _____

Email: _____Day Phone: _____Evening Phone: _____ Occupation _____

ASSOCIATION MEMBERSHIP ENROLLMENT ACKNOWLEDGEMENT

I hereby enroll for membership in the New York State Business Group (NYSBG). As a member of NYSBG, understand that I will be able to access membership products, benefits and services. I acknowledge that member benefits are subject to change without notice. Non U.S. residents are eligible for coverage if they have had a primary residence in the U.S. for 12 consecutive months prior to the effective date of coverage

Signature: X _____ **Date:**_____

APPLICANTS STATEMENT

By signing below, I and the individuals named herein are eligible for insurance and understand that coverage will not begin until the Effective Date shown in the coverage document. I further understand that the coverage applied for is hospital indemnity only coverage and is not intended to cover all medical expenses and that this coverage will not pay benefits during the initial Plan Period for any pre-existing conditions I/we currently have or have had in the past.

Fraud Warning: Any person who knowingly and with intent to defraud an insurance company or any other person files an application for insurance or statement of claim containing any materially false information, or conceals for the propose 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 five thousand dollars and the stated value of the claim for each such violation.

Signed in _____ **X**_____

(City, State) **Signature of Applicant** **Date**

B. COMPLETE THE FOLLOWING INFORMATION ABOUT YOUR ELIGIBLE FAMILY MEMBERS YOU WANT ENROLLED:

(To be eligible. Unmarried dependent children must be under age 19 and living with applicant. If a fulltime student eligibility is to age 25.)

Spouse's Name: _____ Sex (M or F): _____ Age: _____ Date of Birth: _____/_____/_____
Child's Name: _____ Sex (M or F): _____ Age: _____ Date of Birth: _____/_____/_____
Child's Name: _____ Sex (M or F): _____ Age: _____ Date of Birth: _____/_____/_____
Child's Name: _____ Sex (M or F): _____ Age: _____ Date of Birth: _____/_____/_____

C. COMPLETE THE FOLLOWING BENEFICIARY INFORMATION FOR YOUR ACCIDENTAL DEATH & DISMEMBERMENT COVERAGE:

(If this is not answered, the benefit will automatically be paid to your estate.)

Name of Beneficiary:_____ Relationship:_____
Name of Contingent Beneficiary: _____ Relationship:_____

D. SELECT YOUR PLAN AND MONTHLY COST * (Check One) ❑ Premium Advantage ❑ Effective Date (1st of the Month Only)

❑	Individual (Must be age 18 through 64 years old)	$130.00
❑	Individual plus one	$276.07
❑	Family	$356.23
	Add the monthly administration fee	$ 12.50
	Add the ONE time enrollment fee	$ 25.00
	TOTAL AMOUNT DUE	$_____

_____/_____/_____

**Monthly cost includes New York State Business Group membership. Membership benefits are not insurance benefits nor are they affiliated with United States Fire Insurance Company.*

E. AGENT INFORMATION:

COMPANY: _____ **AGENT NAME:**_____ **CODE #:**_____

EMAIL: _____ **PHONE:**_____ **FAX:**_____

AGENT SIGNATURE: _____ **DATE:**_____

MGA/GA: _____ **Code #**_____ **Phone#**_____

Fax or mail the completed enrollment form to your agent or to:

CAI, 180 East Main Street, Suite 205, Patchogue, NY 11772 Phone: 800-427-5358 Fax: (631) 654-0840