healthfirst®
Health Insurance for New Yorkers

Healthfirst Insurance Company, Inc.

Small Group Add/Change/Delete Application

Mailing Address:
Healthfirst Insurance Company, Inc., Commercial Sales, 100 Church Street, New York, NY 10007
Broker Service: 1-855-456-3668
Employer Services: 1-855-949-3668

A. Employee	Group
Employee Insurance ID Number*	Group ID Number
Employee Name	Group Name
_____ _____/____/_____ Employee Signature Date _____ Title	_____ _____/____/_____ Employer Signature Date

B. Transaction	Requested Effective Date**	Required Information
☐ **Addition**	_____/____/_____	**Whom:** ☐ Spouse ☐ Domestic Partner ☐ Dependent(s) **Reason:** ☐ Open Enrollment ☐ Loss of Coverage ☐ Birth/Adoption ☐ Marriage ☐ Partnership ☐ Other: _____
☐ **Termination**	_____/____/_____	**Whom:** ☐ Employee ☐ Spouse/Partner ☐ Dependent(s) ☐ NY Young Adult **Reason:** ☐ Left Employer ☐ Discontinuation of COBRA ☐ Switched Plans ☐ Discontinuation of NY Young Adult ☐ Other:_____
☐ **Change**	_____/____/_____	**Whom:** Last Name: _____ First Name: _____ Middle Initial _____ Effective Date _____/_____/_____ SSN _____-_____-_____ Date of Birth _____/_____/_____ Gender ☐ Male ☐ Female **Reason:** _____ _____
COBRA or State Continuation	_____/____/_____	**Whom:** ☐ Employee ☐ Spouse/Partner ☐ Dependent(s) **Reason:** ☐ Left Employer ☐ Reduction in Hours ☐ Other: _____ See list of Small Group Qualifying Event for more information. Date of termination/Loss of coverage _____/_____/_____
Select a Plan	_____/____/_____	☐ Healthfirst Pro EPO Select your plan level: ☐ Platinum ☐ Gold ☐ Silver ☐ Bronze ☐ Healthfirst Pro Plus EPO Select your plan level: ☐ Platinum ☐ Gold ☐ Silver ☐ Bronze ☐ Young Adult Please select from the plan(s) that your employer is offering to you. Check with your employer or plan administrator if there are any questions.

*Required if you are requesting a termination or change to your coverage.
**Healthfirst Insurance Company, Inc. will assign actual effective date if application is approved.

Employee/Dependent(s) Information

Please complete the form below for the individual(s) you would like to include in the plan.

	Employee	Spouse/Domestic Partner	Dependent 1	Dependent 2
Social Security Number (or Tax Identification Number, if applicable)	_____-____-_____	_____-____-_____	_____-____-_____	_____-____-_____
Last Name				
First Name, Middle Initial				
Phone Number				
Email Address				
Date of Birth (MM/DD/YYYY)	/ /	/ /	/ /	/ /
Gender	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Primary Care Physician (PCP) Name				
PCP ID Number (if available)*				
Currently covered under another insurance?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If Yes, select type:	☐ Medical ☐ Dental	☐ Medical ☐ Dental	☐ Medical ☐ Dental	☐ Medical ☐ Dental
Company Name				
Coverage Beginning/End Dates	___/___/____ – ___/___/____	___/___/____ – ___/___/____	___/___/____ – ___/___/____	___/___/____ – ___/___/____
Policy Number				

*If you do not select a PCP, one will be auto-assigned to you.

Employee/Dependent(s) Information (continued)

	Dependent 3	Dependent 4	Dependent 5	Dependent 6
Social Security Number (or Tax Identification Number, if applicable)	_____-____-_____	_____-____-_____	_____-____-_____	_____-____-_____
Last Name				
First Name, Middle Initial				
Phone Number				
Email Address				
Date of Birth (MM/DD/YYYY)	/ /	/ /	/ /	/ /
Gender	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Primary Care Physician (PCP) Name				
PCP ID Number (if available)*				
Currently covered under another insurance?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If Yes, select type:	☐ Medical ☐ Dental	☐ Medical ☐ Dental	☐ Medical ☐ Dental	☐ Medical ☐ Dental
Company Name				
Coverage Beginning/End Dates	___/___/____ – ___/___/____	___/___/____ – ___/___/____	___/___/____ – ___/___/____	___/___/____ – ___/___/____
Policy Number				

*If you do not select a PCP, one will be auto-assigned to you.