healthfirst®
Health Insurance for New Yorkers

Healthfirst Insurance Company, Inc.
Small Group
Employee Enrollment Application

Mailing Address:
Healthfirst Insurance Company, Inc., Commercial Sales, 100 Church Street, New York, NY 10007

Please print neatly using black or blue ink, complete the enrollment form **in full**, and **sign** the last page. Incomplete or unsigned forms will not be processed.

Section 1 | Company Information

To be completed by Plan Administrator:

Company Name	Billing Group (If Applicable)	Group Number
Effective Date / /	Title	Date of Hire (MM/DD/YYYY) / /
Employer Signature	Date / /	

Section 2 | Transaction Type

(check all that apply)

☐ Open Enrollment ☐ New Hire ☐ Rehire ☐ Young Adult

☐ COBRA/State Continuation Date of Termination/Loss of Coverage: ___ /___ /____

Section 3 | Coverage Selection

Please refer to your employer's health insurance plan option(s) and write your choice here:

_____

Please select from the plan(s) that your employer is offering. Check with your employer or plan administrator if there are any questions.

Section 4 | Employee Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Section 5 | Employee/Dependent(s) Information

	Employee	Spouse	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.

Section 5 | 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.

Section 6 | Conditions of Enrollment

On behalf of myself and the dependents listed in Section 5, I agree to or with the following:

1. I understand that my employer's application will determine coverage and that there is no coverage unless and until both the eligible-employee enrollment form and the employer application have been accepted and approved by Healthfirst.
2. I understand and agree that this enrollment form may be transmitted to Healthfirst or its agent by my employer or its agent.
3. The plan certificate of coverage will determine the rights and responsibilities of member(s). It will govern in the event they conflict with any benefits comparison, summary, or other description of the plan.

Section 7 | Misrepresentation

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.

Employee Signature: _____ Date: _____ / _____ / _____

Section 8 | Acknowledgment and Signature

I consent to the release of any health information about me and my dependents for whom I can give consent, by our health care providers to Healthfirst and by Healthfirst to our health care providers, as reasonably necessary for Healthfirst or our providers to carry out treatment, payment, or health care operations. I agree that the information released for treatment, payment and health care operations may include confidential HIV, mental health and alcohol and substance abuse information about me and my dependents to the extent permitted by law. This consent will expire one year after the end of my enrollment with Healthfirst.

I represent that to the best of my knowledge and belief all information supplied in this form is true and complete. I have read, and I agree to, information listed on this Healthfirst Insurance Company, Inc. Small Group Employee Enrollment Form. I understand that if I do not sign this form within 30 days from the date first eligible or within 30 days of the qualifying life event (i.e., marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.), I will be considered a late enrollee, which may affect the effective date of coverage for me and my dependents. I am employed by the employer shown in Section 1, and I am working full time at least 20 hours per week for this employer at the regular place of business. I authorize Healthfirst to electronically transmit the information contained in this application. In addition, I consent to receive and/or communicate with Healthfirst electronically. I may withdraw my consent for electronic communication by contacting Member Services at the number on my ID card and request that future communication be sent in written form.

Employee Signature	Employee Email Address	Date (MM/DD/YYYY)
_____	_____	____ /____ /_____

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Notice of Non-Discrimination

Healthfirst complies with Federal civil rights laws. **Healthfirst** does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Healthfirst provides the following:

- Free aids and services to people with disabilities to help you communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose first language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call **Healthfirst** at **1-866-305-0408**. For TTY/TDD services, call 1-888-542-3821.

If you believe that **Healthfirst** has not given you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with our **Civil Rights Coordination** team by:

- **Mail:** Member Services, P.O. Box 5165, New York, NY, 10007
- **Phone: 1-866-305-0408** (for TTY/TDD services, call 1-888-542-3821)
- **Fax:** 1-212-801-3250
- **In person:** 100 Church Street, New York, NY 10007
- **Email:** Contact Healthfirst via email by submitting an inquiry or grievance at **http://healthfirst.org/members/contact/**.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by:

- **Web:** Office for Civil Rights Complaint Portal at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**
- **Mail:** U.S. Department of Health and Human Services
  200 Independence Avenue SW., Room 509F, HHH Building
  Washington, DC 20201
  Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**
- **Phone: 1-800-368-1019** (TTY/TDD 800-537-7697)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-305-0408, TTY/TDD: 1-888-867-4132.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-866-305-0408, TTY/TDD: 1-888-542-3821。

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم العناية بالعملاء 1-866-305-0408 (لخدمات الهاتف النصي/جهاز التواصل عن بعد للصم، اتصل برقم 1-888-542-3821).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-305-0408, TTY/TDD: 1-888-542-3821 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-305-0408, телетайп: 1-888-542-3821.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-305-0408, TTY/TDD: 1-888-542-3821.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-305-0408, TTY/TDD: 1-888-542-3821.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-305-0408, TTY/TDD: 1-888-542-3821.

אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-888-542-3821 :TTY/TDD 1-866-305-0408.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-305-0408, TTY/TDD: 1-888-542-3821.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-305-0408, TTY/TDD: 1-888-542-3821.

দৃষ্টি আকর্ষণ: যদি আপনি বাংলায় কথা বলেন তাহলে বিনামূল্যে ভাষা বিষয়ক সহায়তা আপনার জন্য উপলব্ধ রয়েছে। গ্রাহক সেবায় 1-866-305-0408 (TTY/TDD পরিষেবার জন্য, 1-888-542-3821 নম্বরে ফোন করুন) নম্বরে ফোন করুন।

KUJDES: Nëse flisni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-866-305-0408, TTY/TDD: 1-888-542-3821.

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-866-305-0408, Γραφομηχανή τηλεφώνου (TTY) / Συσκευή τηλεπικοινωνιών για κωφούς (TDD): 1-888-542-3821.

توجہ: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کسٹمر کیر سے گفتگو کرنے کے لئے اس نمبر (1-866-305-0408) پر اور TTY/TDD کے لئے (1-888-542-3821) پر رابطہ کریں۔