

Mailing Address:

Healthfirst Insurance Company, Inc., P.O. Box 1566, New York, NY 10008-1516

Broker Services: 1-855-456-3668

Employer Services: 1-855-949-3668

Section 1 Employee/Group			
Healthfirst Member ID*		Group ID	
Employee Name		Group Name	
Employee Signature	Date	Employer Signature	Date
_____ / ____ / ____	_____ / ____ / ____	_____ / ____ / ____	_____ / ____ / ____
Class <input type="checkbox"/> I <input type="checkbox"/> II		Print Employer Name	Title
		_____	_____

Section 2 Transaction			
	Requested Effective Date**	Required Information	
<input type="checkbox"/> Addition	_____ / ____ / ____	Who <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Dependent(s) Reason <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Marriage <input type="checkbox"/> Partnership <input type="checkbox"/> Other _____	
<input type="checkbox"/> Termination	_____ / ____ / ____	Who <input type="checkbox"/> Employee <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Dependent(s) <input type="checkbox"/> NY Young Adult† Reason <input type="checkbox"/> Left Employer <input type="checkbox"/> Discontinuation of COBRA/State Continuation <input type="checkbox"/> Switched Plans <input type="checkbox"/> Discontinuation of NY Young Adult <input type="checkbox"/> Other _____	
<input type="checkbox"/> Change	_____ / ____ / ____	Who Last Name _____ First Name _____ Middle Initial _____ SSN ____ - ____ - ____ Date of Birth ____ / ____ / ____ Gender <input type="checkbox"/> Male <input type="checkbox"/> Female Mailing Address _____ Physical Address _____	
COBRA or State Continuation	_____ / ____ / ____	Who <input type="checkbox"/> Employee <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Dependent(s) Reason <input type="checkbox"/> Left Employer <input type="checkbox"/> Reduction in Hours <input type="checkbox"/> Other _____ Date of termination/loss of coverage ____ / ____ / ____	
Choose a Plan	_____ / ____ / ____	<input type="checkbox"/> Healthfirst Pro EPO <input type="checkbox"/> Healthfirst Pro Plus EPO <input type="checkbox"/> Young Adult† Choose from the plan(s) that your employer is offering and write the name. _____	

*Required if you are requesting a termination of or change to your coverage.

**Healthfirst Insurance Company, Inc. will assign actual effective date if application is approved. Healthfirst reserves the right to request additional documentation as part of our review process.

†Check this box only if your employer's coverage does not cover dependents up to age 29 and you would like to purchase a separate policy for the age 29 dependent.

Section 3 | Employee/Dependent(s) Information

	Employee/Subscriber	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*	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Primary Care Provider** (PCP) Name				
PCP ID Number				
Currently covered under another insurance?†	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If YES, select type:	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Medical <input type="checkbox"/> Dental
Company Name				
Coverage Beginning/ End Dates	____/____/____ - ____/____/____	____/____/____ - ____/____/____	____/____/____ - ____/____/____	____/____/____ - ____/____/____
Policy Number				

*These fields must be filled out.

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

†Indicate if you will have other coverage under another plan after enrolling with Healthfirst.

Section 3 | 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*	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Primary Care Provider** (PCP) Name				
PCP ID Number				
Currently covered under another insurance?†	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If YES, select type:	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Medical <input type="checkbox"/> Dental
Company Name				
Coverage Beginning/ End Dates	____/____/____ - ____/____/____	____/____/____ - ____/____/____	____/____/____ - ____/____/____	____/____/____ - ____/____/____
Policy Number				

*These fields must be filled out.

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

†Indicate if you will have other coverage under another plan after enrolling with Healthfirst.



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 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 Healthfirst by:

- **Mail:** Healthfirst Member Services, P.O. Box 5165, New York, NY, 10274-5165
- **Phone:** **1-866-305-0408** (for TTY services, call 1-888-542-3821)
- **Fax:** 1-212-801-3250
- **In person:** 100 Church Street, New York, NY 10007
- **Email:** <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 800-537-7697)

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-866-305-0408 (TTY 1-888-542-3821).	English
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-305-0408 (TTY: 1-888-867-4132).	Spanish
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: 1-888-542-3821)。	Chinese
ملحوظة: إذا كنت تتحدث العربية، فسوف تتوفر خدمات المساعدة اللغوية لك بالمجان. اتصل برقم 1-866-305-0408 (TTY: 1-888-542-3821).	Arabic
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다 1-866-305-0408 (TTY: 1-888-542-3821).번으로 전화해 주십시오.	Korean
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-305-0408 (TTY: 1-888-542-3821).	Russian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-305-0408 (TTY: 1-888-542-3821).	Italian
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-305-0408 (TTY: 1-888-542-3821).	French
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-305-0408 (TTY: 1-888-542-3821).	French Creole
אויפֿמערקזאַם: אויב איר רעדט אידיש, זענען פארהאן פאר איין שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-866-305-0408 (TTY: 1-888-542-3821).	Yiddish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-305-0408 (TTY: 1-888-542-3821).	Polish
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: 1-888-542-3821).	Tagalog
লক্ষ্য করুন: যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-৮৬৬-৩০৫-০৪০৮ (TTY: 1-888-542-3821)।	Bengali
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-866-305-0408 (TTY: 1-888-542-3821).	Albanian
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-866-305-0408 (TTY: 1-888-542-3821).	Greek
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں 1-866-305-0408 (TTY: 1-888-542-3821)۔	Urdu