

PLEASE USE BLACK INK ONLY. For address changes simply call (518) 641-3140 or 1-877-269-2134 or visit www.cdpbp.com. There is no need to complete this form.



Enrollment Application/Change Form

CDPHP Universal Benefits, Inc.
 Patron Creek Corporate Center
 1223 Washington Avenue • Albany, NY 12206-1057
 (518) 641-5000 or 1-800-993-7299

AchievaCare PPO
 HSA High Deductible PPO
 Aetna/Care EPO

EMPLOYER USE

Date hired: ___/___/___ Date of status change: ___/___/___

Part-time to full-time
 Temporary to permanent
 Union to non-union
 Other

Date coverage is to be effective: _____

Group/Division #: _____

Employee Status: A. Full-time
 Part-time (hours per week) _____
 B. Active
 Retiree
 Salaried
 Union
 Other

Group Administrator Initials (required): _____

EXPLANATION

Check all that apply

New Enrollment
 Open Enrollment
 Name Change
 Qualifying Event/Reason:
 Loss of Coverage (include proof—HIPAA Cert.)
 Add Dependent
 Effective Date: _____
 Termination
 Employee Terminated
 Moved Out of Area
 Remove Dependent Only
 Open Enrollment—Transferred to another plan
 Dissatisfaction
 Cost
 Spouse's Coverage
 Other: _____ Effective Date: _____

SUBSCRIBER

1. First Name _____ M.I. _____ Last Name _____

2. Street Address _____ Apt. # _____

3. City _____ State _____ Zip Code _____

4. Your Social Security # _____

5. Telephone: Home: () _____ Works: () _____

6A. Employer Name _____

6B. Chamber/Association _____

7. Primary language if other than English: _____

8. MEMBER INFORMATION

Address	Relationship	Date of Birth (mm/dd/yyyy)	Social Security Number	Medicare A & B* Effective Date *Copy of Medicare Card must be attached.	Full-Time Student	Previous Health Care Coverage Effective Dates (Include copy of HIPAA Cert.)
Applicant	Self <input type="checkbox"/> M <input type="checkbox"/> F	/ /		<input type="checkbox"/> A / / <input type="checkbox"/> B / /		Yes Dates: / / to / / Previous Carrier: <input type="checkbox"/> No
01	Husband Wife Other	/ /		<input type="checkbox"/> A / / <input type="checkbox"/> B / /		Yes Dates: / / to / / Previous Carrier: <input type="checkbox"/> No
02	Son Daughter	/ /		<input type="checkbox"/> A / / <input type="checkbox"/> B / /	<input type="checkbox"/> Yes <input type="checkbox"/> No	Yes Dates: / / to / / Previous Carrier: <input type="checkbox"/> No
03	Son Daughter	/ /		<input type="checkbox"/> A / / <input type="checkbox"/> B / /	<input type="checkbox"/> Yes <input type="checkbox"/> No	Yes Dates: / / to / / Previous Carrier: <input type="checkbox"/> No
04	Son Daughter	/ /		<input type="checkbox"/> A / / <input type="checkbox"/> B / /	<input type="checkbox"/> Yes <input type="checkbox"/> No	Yes Dates: / / to / / Previous Carrier: <input type="checkbox"/> No

9. DEPENDENT

Full-time college students age 19 and over: _____ Expected Date of Graduation: _____

School Name and Address: _____

Do you have a disabled dependent beyond age 19?
 No Yes (list name[s]): _____

10. OTHER INSURANCE

Policyholder name: _____ Relationship: Self Spouse Child

Social Security Number: _____ Date of Birth: _____ / /

Insurance Carrier: _____ Policy #: _____ Effective Date: _____

Address: _____ Employer Name: _____

Telephone: _____ Covered Individuals: _____

Plan Type: Self Only Self & Family Hospital Medical Drug Dental Vision

Applicant's Signature _____ Date _____

11. SIGNATURE

AGREEMENT: I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge and that I have read the important information on the reverse side of this form.

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 \$5,000 and the stated value of the claim for each such violation.