



Enrollment Application/Change Form

P.O. Box 710, Buffalo, NY 14231-0710 independenthealth.com

Benefit Administrator Initials	<input type="text"/>
Today's Date	<input type="text"/>
MM / DD / YYYY	

1. Employer Information/Plan Selection – Employer Information to be completed by Group Benefits Administrator

Group
 Individual/Conversion
 HRA
 FSA
 Parking/Transit

Group #	Subgroup #	Plan Number	Effective Date
<input type="text"/>	<input type="text"/>	<input type="text"/>	MM / DD / YYYY

Employer Name

Chamber or Association Name (if applicable)

2. Reason for Request/Qualifying Event

Add:
 Adoption
 Involuntary Loss of Coverage
 Newborn
 Open Enrollment
 Change in Employment Status
 Legal Guardianship
 New Hire
 Relocation
 COBRA (indicate reason below)
 Marriage/Domestic Partner
 New Student

Date of Qualifying Event (i.e., date of hire, date of marriage, date of placement):

Change:
 Address/Phone Number
 Employee Status (complete status below)
 Last Name

Cancel Coverage:
 Subscriber
 Dependent (indicate name below – use space in Dependent Section for additional dependent names)

Dependent Last Name	Dependent First Name
<input type="text"/>	<input type="text"/>

Which coverage are you canceling? (check all that apply)
 Medical
 FSA
 HRA
 Parking/Transit

Reason for Cancellation:

<input type="checkbox"/> Deceased	<input type="checkbox"/> Layoff	<input type="checkbox"/> No Longer Eligible	<input type="checkbox"/> Personal Reasons
<input type="checkbox"/> Dependent Age	<input type="checkbox"/> Employee Cancel	<input type="checkbox"/> Nonpayment	<input type="checkbox"/> Retired
<input type="checkbox"/> Dissatisfaction	<input type="checkbox"/> Moved Out of Area	<input type="checkbox"/> Now Under Spouse's Plan	<input type="checkbox"/> Terminated Employment
			<input type="checkbox"/> Transferring to Another Group

3. Employee Status Information

Employee Status/Change in Status
 Status Effective Date
 Indicate reason for COBRA:

<input type="checkbox"/> Active <input type="checkbox"/> COBRA <input type="checkbox"/> Retired <input type="checkbox"/> Inactive	MM / DD / YYYY	<input type="checkbox"/> Left Employer <input type="checkbox"/> Retirement <input type="checkbox"/> Death of Spouse <input type="checkbox"/> Divorce/Legal Separation <input type="checkbox"/> Reduction in Hours <input type="checkbox"/> Dependent Reached Max Age <input type="checkbox"/> Loss of Student Status
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4. Employee Information - Provide information as it appears on your Social Security Card

Employee Last Name	Employee First Name	M.I.
<input type="text"/>	<input type="text"/>	<input type="text"/>
Address	Apt./Suite	Primary Language (if other than English)
<input type="text"/>	<input type="text"/>	<input type="text"/>
City	State	Zip Code
<input type="text"/>	<input type="text"/>	<input type="text"/>
E-mail Address	<input type="radio"/> Male <input type="radio"/> Female	
<input type="text"/>		

Social Security # (required)	Date of Birth	Primary Telephone (include area code)
<input type="text"/>	MM / DD / YYYY	(<input type="text"/>) <input type="text"/>

Home Work Cell

5. Employee Prior Health Insurance — List 12 months of cumulative coverage immediately before this application for coverage, including pertinent dates of prior coverage

Insurance Carrier Name	From (Date)	To (Date)
<input type="text"/>	MM / DD / YYYY	MM / DD / YYYY
Insurance Carrier Name	From (Date)	To (Date)
<input type="text"/>	MM / DD / YYYY	MM / DD / YYYY

Was prior coverage:
 single or
 family coverage?

6. Employee Other Health Insurance: Indicate if you will have other health insurance while enrolled with Independent Health

Insurance Carrier Name Policy Number Policy Effective Date

Policy Holder Last Name First Name

Medicare – Please indicate reason for Medicare eligibility if applicable
 Age 65+ Disability End Stage Renal Disease **Are you currently covered by Medicare Part A or Part B?** Yes No
 Medicare # (HICN) Part A Effective Date Part B Effective Date

7. Provider Selection – Provide physician information from Independent Health’s directory

Primary Care Physician # Last Name First Name

City State

OB/GYN # Last Name First Name

City State

8. Dependent #1 Information – Provide all information as it appears on dependent’s Social Security Card

Dependent Last Name Dependent First Name M.I.

Social Security # (required) - - Date of Birth Male Female

Relationship to Employee Spouse Child Other (i.e., adoption, grandchild, legal guardian, etc.)
Legal documentation may be required

If dependent is disabled and over the age of 26, please call (716) 631-8701 or 1-800-501-3439 to request a Dependent Disability Waiver.

Dependent Other Health Insurance/Medicare – Indicate if dependent will have other health insurance while enrolled

Insurance Name Policy Number Policy Effective Date

Policy Holder Last Name First Name

Medicare – Please indicate reason for Medicare eligibility if applicable
 Age 65+ Disability End Stage Renal Disease **Are they covered by Medicare Part A or Part B?** Yes No
 Medicare # (HICN) Part A Effective Date Part B Effective Date

Dependent Physician Selection – Provide physician information from Independent Health’s directory

Primary Care Physician # Last Name First Name

City State

OB/GYN # Last Name First Name

City State

