New York Member Enrollment Form

Montefiore | Nyack

Highland Medical, P.C.

A. Group Information (To be completed by the **employer**)					**Please print neatly using black or blue ballpoint pen • ALL DATES MUST BE: MM/DD/YYYY**
Group Number / Group Name	Plan CSP / Billing Group	Date of Hire / /	Effective Date / /	Occupation	
☐ On Leave of Absence ☐ Retired ☐ Union Employee ☐ Disabled	COBRA/Young Adult/SC Qualifying Event	Event Date / /	**Employer Signature** X	Date / /	

B. Applicant Details (To be completed by the **employee**)	**Employee/Subscriber**	**Spouse**	**Child**	**Child**
Social Security Number:				
Last Name:				
First Name, Middle Initial:				
Date of Birth: (MM/DD/YYYY)	/ /	/ /	/ /	/ /
Gender and Disability Status: (Check appropriate boxes.)	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled
Primary Care Physician (PCP) ID Number: PCP Name: (If an existing patient of PCP, check "Yes".)	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Check all that apply:		☐ Domestic Partner	☐ Full-time Student ☐ Young Adult	☐ Full-time Student ☐ Young Adult
Prior Carrier (List coverage prior to this.) ☐ Same for all	Carrier: Policy Number: From Date / / Thru date:: / /	Carrier: Policy Number: From Date / / Thru date:: / /	Carrier: Policy Number: From Date / / Thru date:: / /	Carrier: Policy Number: From Date / / Thru date:: / /
C. Coordination of Benefits	**Employee/Subscriber**	**Spouse**	**Child**	**Child**
Medicare Coverage Check appropriate box and list effective date:	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /
Pharmacy ☐ Same for all **Effective Date:** / /	Policy Number: Carrier: Policy Holder: Group Number: BIN: PCN:	Policy Number: Carrier: Policy Holder: Group Number: BIN: PCN:	Policy Number: Carrier: Policy Holder: Group Number: BIN: PCN:	Policy Number: Carrier: Policy Holder: Group Number: BIN: PCN:
Medical ☐ Same for all	Policy Number: Carrier: Policy Holder: Effective Date: / /	Policy Number: Carrier: Policy Holder: Effective Date: / /	Policy Number: Carrier: Policy Holder: Effective Date: / /	Policy Number: Carrier: Policy Holder: Effective Date: / /

Employee's/Young Adult's Address (Apt #) City State Zip	**Employee's/Young Adult's Signature** X	Date / /

☐ EPO

☐ PPO