

**New York State Health Insurance Program
Special Option Transfer Request for April 1, 2007
Notice of Intent to Enroll in an HMO**

**DEADLINE:
March 30, 2007**

Please fill in this form and send it to your agency Health Benefits Administrator, along with the completed Special Option Transfer Request Form.

Enrollee Name:	Enrollee Social Security Number:	Enrollee Date of Birth:	
Street Address:	County:	State:	ZIP Code:
Telephone Number: ()	Medicare Eligible? ☐ Yes ☐ No	If Yes: Part A Effective Date: _____ Part B Effective Date: _____	
Coverage Type: ☐ Individual ☐ Family (complete back side of this form)			

Indicate your choices (call the HMO for a list of participating providers):

Health Center:	Primary Physician:	Pharmacy:
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Effective APRIL 1, 2007, please change my health insurance option to:

Option Code:	Plan Name:
Date:	Enrollee's Signature:

If you have Family coverage, please complete this information for all eligible dependents. Photocopy this form to add additional dependents, if necessary.

Relationship:	Name:	Social Security Number:	Date of Birth:
Health Center:	Primary Physician:		Pharmacy:

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Any other Enrolled Children? ☐ Yes ☐ No (attach a separate sheet with information requested above)