DEADLINE:
March 30, 2007

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

Please fill in this form and send it directly to your new HMO. Use the address that appears on the HMO page in Choices.

<table>
<tr><td>Enrollee Name:</td><td colspan="2">Enrollee Social Security Number:</td><td colspan="2">Enrollee Date of Birth:</td></tr>
<tr><td>Street Address:</td><td colspan="2">County:</td><td>State:</td><td>ZIP Code:</td></tr>
<tr><td>Telephone Number:
( )</td><td rowspan="2">Medicare Eligible?
☐ Yes ☐ No</td><td colspan="3" rowspan="2">If Yes:
Part A Effective Date: _____
Part B Effective Date: _____</td></tr>
<tr><td>Coverage Type:
☐ Individual ☐ Family (complete back side of this form)</td></tr>
</table>

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

Health Center:	Primary Physician:	Pharmacy:

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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Health Center:	**Primary Physician:**		**Pharmacy:**

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