

Notice of Intent to Enroll in an HMO

Please fill in this form and send it to your HMO at least 30 days prior to the effective date you are requesting.
Use the address that appears on the appropriate HMO page.

Name _____	Date of Birth _____
Street Address _____	Social Security Number _____
County _____	Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No
City or Post Office _____	If yes: Part A Effective Date: _____
State _____ ZIP Code _____	Part B Effective Date: _____
Telephone Number (____) _____	Coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Family
Health Center/Primary Physician/Pharmacy (Indicate your choices)	

Effective _____, **please change my health insurance option to:**

Enter date here (must be the first of a month)

Option Code Number _____ Plan Name _____

Date _____ Enrollee's Signature _____

If you have Family coverage, please also complete the bottom portion of this form.

Name of Spouse/Domestic Partner (If Covered Dependent) _____

Spouse/Domestic Partner Employed? Yes No

If Employed, Name of Employer _____

Does Spouse/Domestic Partner have other coverage? Yes No If yes, Individual Family

Date of Birth of Spouse/Domestic Partner _____

Medicare? Yes No If yes: Part A Effective Date: _____ Part B Effective Date: _____

Health Center/Primary Physician/Pharmacy of Spouse/Domestic Partner:

Name of Child (if Covered Dependent) _____

Employed? Yes No If Employed, Name of Employer _____

Does Dependent have other coverage? Yes No If yes, Individual Family

Dependent's Date of Birth _____

Medicare? Yes No If yes: Part A Effective Date: _____ Part B Effective Date: _____

Dependent's Health Center/Primary Physician/Pharmacy

Any other Enrolled Children? Yes No If any other information is required, the HMO will contact you.

I have mailed the "NYSHIP Option Transfer Request" form to the New York State Department of Civil Service.

Please indicate date sent ____/____/____.