

Notice of Intent to Enroll in an HMO

Please fill in this form and send it to your HMO as early as possible 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? Yes No
City or Post Office _____ If yes: Part A Effective Date: _____
State _____ ZIP Code _____ Part B Effective Date: _____

Telephone Number (____) _____ Coverage: Individual 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.

Note: If you have Individual coverage, but want Family coverage, see page 3 for information on how to change.

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 ____/____/____.

