

HIP Subscriber/Member Enrollment Form

Last Name _____ First Name _____ M.I. _____ Sex _____ Social Security Number _____
 Street Address _____ Apt. _____ City _____ Birth Date _____ State _____ Zip Code _____
 Telephone #: Home: (____) _____-____ Work: (____) _____
 E-Mail Address: _____

Were you ever a member of HIP? NO YES
 If yes, indicate policy number(s): _____

Primary Care Physician: _____ (not required for EPO/PO members)
 OB/GYN/Selection: _____ (Optional)
 Physician Name _____ Physician ID Number _____

Prior Health Insurance Information
 Carrier Name _____ Coverage Begin Date ____/____/____ Coverage End Date ____/____/____
 Effective Date: ____/____/____

Qualifying Event: Birth/Adoption Marriage Loss of Coverage New Hire Other
 Are you covered by any other Health Insurance or Medicare?
 NO YES If yes, indicate:
 Insurance Co. Name: _____ Insurance Co. Telephone #: _____
 Type of Coverage: _____ Policy #: _____ Effective Date: ____/____/____

*** If you are enrolling for your spouse and/or children please list each one below - see Election of Coverage for eligibility**

Last Name (if different)	First Name	Soc. Sec. No.	Sex	Relationship	Birth Date	Check if disabled	Primary Care Physician Name/Number (not required for EPO/PO members)	OB/GYN Selection Name/Number (Optional)	Coverage Begin Date	Coverage End Date
_____	_____	_____	_____	<input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Other	____/____/____	_____	_____	_____	____/____/____	____/____/____
_____	_____	_____	_____	<input type="checkbox"/> Son <input type="checkbox"/> Daughter	____/____/____	_____	_____	_____	____/____/____	____/____/____
_____	_____	_____	_____	<input type="checkbox"/> Son <input type="checkbox"/> Daughter	____/____/____	_____	_____	_____	____/____/____	____/____/____
_____	_____	_____	_____	<input type="checkbox"/> Son <input type="checkbox"/> Daughter	____/____/____	_____	_____	_____	____/____/____	____/____/____

Prior Health Insurance Information
 Carrier Name _____ Coverage Begin Date ____/____/____ Coverage End Date ____/____/____
 Your signature is required to process this form. Your signature attests that you have read the reverse side of this form
 Applicant must sign here: _____ Date _____

This Section to be Completed by Employer/Contractor Group
 Name of Group _____ Group Number _____
 Requested Effective Date _____ Hire Date _____ Employee Title _____ Date Submitted to HIP _____ Approved by (Representative of Benefits Administrator) _____
 Select One: HIP PRIME HMO HIP access1 HIP PRIME PPO
 HIP PRIME POS HIP accessII HIP PRIME PPO
 Type of Coverage: Individual Family Employee & Spouse Employee & Child
 PROCESSED BY _____ RECEIVED DATE _____ FOR HIP USE ONLY
 PROCESSED DATE _____

Instructions to Benefits Administrators or Group Representatives: For Groups with 50 employees or less, you MUST complete Section A on the reverse side of this form. Required documentation MUST be attached to this Enrollment Form to be processed.
 HIP HEALTH PLAN OF NEW YORK, P.O. Box 2806, New York, NY 10116-2806