healthfirst
Health Insurance for New Yorkers

Healthfirst Insurance Company, Inc.

Small Group
Add/Change/Delete Application

Mailing Address:
Healthfirst Insurance Company, Inc., P.O. Box 1566, NY, NY 10277-2138

Broker Services: 1-855-456-3668

Employer Services: 1-855-949-3668

Section 1 | Employee/Group

Healthfirst Member ID*	Group ID
Employee Name	Group Name
Employee Signature _____ Date _____/_____/_____	Employer Signature _____ Date _____/_____/_____
Title _____	Print Employer Name _____

Section 2 | Transaction

	Requested Effective Date**	Required Information
☐ Addition	_____/_____/_____	**Whom** ☐ Spouse ☐ Domestic Partner ☐ Dependent(s) **Reason** ☐ Open Enrollment ☐ Loss of Coverage ☐ Birth/Adoption ☐ Marriage ☐ Partnership ☐ Other _____
☐ Termination	_____/_____/_____	**Whom** ☐ Employee ☐ Spouse/Partner ☐ Dependent(s) ☐ NY Young Adult† **Reason** ☐ Left Employer ☐ Discontinuation of COBRA/State Continuation ☐ Switched Plans ☐ Discontinuation of NY Young Adult ☐ Other _____
☐ Change	_____/_____/_____	**Whom** Last Name_____ First Name_____ Middle Initial _____ Effective Date of Change ___/___/___ SSN ___-___-____ Date of Birth _____/_____/_____ Gender ☐ Male ☐ Female **Reason** _____
COBRA or State Continuation	_____/_____/_____	**Whom** ☐ Employee ☐ Spouse/Partner ☐ Dependent(s) **Reason** ☐ Left Employer ☐ Reduction in Hours ☐ Other _____ Date of termination/loss of coverage _____/_____/_____
Select a Plan	_____/_____/_____	☐ Healthfirst Pro EPO ☐ Healthfirst Pro Plus EPO ☐ Young Adult† **Please select from the plan(s) that your employer is offering to you. Check with your employer or plan administrator if there are any questions.**

*Required if you are requesting a termination of or change to your coverage.

**Healthfirst Insurance Company, Inc. will assign actual effective date if application is approved. Healthfirst reserves the right to request additional documentation as part of our review process.

†Check this box only if your employer's coverage does not cover dependents up to age 29 and you would like to purchase a separate policy for the age 29 dependent.

Section 3 | Employee/Dependent(s) Information

	Employee/Subscriber	Spouse/Domestic Partner	Dependent 1	Dependent 2
Social Security Number (or Tax Identification Number, if applicable)	_____-_____-_____	_____-_____-_____	_____-_____-_____	_____-_____-_____
Last Name*				
First Name, Middle Initial*				
Phone Number				
Email Address				
Date of Birth (MM/DD/YYYY)*	/ /	/ /	/ /	/ /
Gender*	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Primary Care Provider** (PCP) Name				
PCP ID Number (if available)				
Currently covered under another insurance?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If YES, select type:	☐ Medical ☐ Dental	☐ Medical ☐ Dental	☐ Medical ☐ Dental	☐ Medical ☐ Dental
Company Name				
Coverage Beginning/ End Dates	___/___/___ – ___/___/___	___/___/___ – ___/___/___	___/___/___ – ___/___/___	___/___/___ – ___/___/___
Policy Number				

*These fields must be filled out.
**If you do not select a PCP, one will be auto-assigned to you.

Section 3 | Employee/Dependent(s) Information (continued)

	Dependent 3	Dependent 4	Dependent 5	Dependent 6
Social Security Number (or Tax Identification Number, if applicable)	_____-_____-_____	_____-_____-_____	_____-_____-_____	_____-_____-_____
Last Name*				
First Name, Middle Initial*				
Phone Number				
Email Address				
Date of Birth (MM/DD/YYYY)*	/ /	/ /	/ /	/ /
Gender*	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Primary Care Provider** (PCP) Name				
PCP ID Number (if available)				
Currently covered under another insurance?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If YES, select type:	☐ Medical ☐ Dental	☐ Medical ☐ Dental	☐ Medical ☐ Dental	☐ Medical ☐ Dental
Company Name				
Coverage Beginning/ End Dates	___/___/___ – ___/___/___	___/___/___ – ___/___/___	___/___/___ – ___/___/___	___/___/___ – ___/___/___
Policy Number				

*These fields must be filled out.
**If you do not select a PCP, one will be auto-assigned to you.

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Notice of Non-Discrimination

Healthfirst complies with Federal civil rights laws. **Healthfirst** does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Healthfirst provides the following:

- Free aids and services to people with disabilities to help you communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose first language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call **Healthfirst** at **1-866-305-0408**. For TTY services, call 1-888-542-3821.

If you believe that **Healthfirst** has not given you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with **Healthfirst** by:

- **Mail:** Healthfirst Member Services, P.O. Box 5165, New York, NY, 10274-5165
- **Phone: 1-866-305-0408** (for TTY services, call 1-888-542-3821)
- **Fax:** 1-212-801-3250
- **In person:** 100 Church Street, New York, NY 10007
- **Email: http://healthfirst.org/members/contact/**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by:

- **Web:** Office for Civil Rights Complaint Portal at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**
- **Mail:** U.S. Department of Health and Human Services
  200 Independence Avenue SW., Room 509F, HHH Building
  Washington, DC 20201
  Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**
- **Phone: 1-800-368-1019** (TTY 800-537-7697)

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-866-305-0408 (TTY 1-888-542-3821).	English
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-305-0408 (TTY: 1-888-867-4132).	Spanish
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-305-0408 (TTY: 1-888-542-3821).	Chinese
ملحوظة: إذا كنت تتحدث العربية، فسوف تتوفر خدمات المساعدة اللغوية لك بالمجان. اتصل برقم 1-866-305-0408 (TTY: 1-888-542-3821).	Arabic
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다 1-866-305-0408 (TTY: 1-888-542-3821).번으로 전화해 주십시오.	Korean
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-305-0408 (TTY: 1-888-542-3821).	Russian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-305-0408 (TTY: 1-888-542-3821).	Italian
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-305-0408 (TTY: 1-888-542-3821).	French
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-305-0408 (TTY: 1-888-542-3821).	French Creole
אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון 1-866-305-0408 (TTY: 1-888-542-3821). רופט אפצאל.	Yiddish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-305-0408 (TTY: 1-888-542-3821).	Polish
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-305-0408 (TTY: 1-888-542-3821).	Tagalog
লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১1-866-305-0408 (TTY: 1-888-542-3821).	Bengali
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-866-305-0408 (TTY: 1-888-542-3821).	Albanian
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-866-305-0408 (TTY: 1-888-542-3821).	Greek
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-866-305-0408 (TTY: 1-888-542-3821).	Urdu