USE BLACK INK ONLY.

Student Health Plan Enrollment Application/Change Form

CDPHP®
500 Patroon Creek Blvd.
Albany, NY 12206-1057
(518) 641-3700 or 1-800-777-2273

A. EXPLANATION *(CHECK ALL THAT APPLY)*

Student:
- ◯ Early Enrollment
- ◯ Late Enrollment
- ◯ Voluntary Enrollment

Dependent(s):
- ◯ New Enrollment
- ◯ Add Dependent(s)
- ◯ Remove Dependent(s)
- ◯ Change Dependent(s)

Eligible:
- ◯ Dependent/Child/Spouse
- ◯ Part-time/Graduate Student
- ◯ 90-Day Extension

B. COVERAGE INFORMATION

Requested Effective date: _____

School Name: _____

Student Name & ID Number: _____

C. SUBSCRIBER INFO

1. Last Name _____ First Name _____ M.I. _____

2a. Street Address _____ Apt. # _____

2b. City _____ State ____ ZIP _____

3a. Mailing Address ◯ Check here if same as street address Apt. # _____

3b. City _____ State ____ ZIP _____

4. Telephone: Primary _____ Secondary _____

5. E-mail Address _____

6. Social Security Number ***(Required)*** _____

7. Date of Birth ***(Required)*** _____

Sex: ◯ *M* ◯ *F*

Primary Language *(optional*)*: Spoken: _____ Written: _____

Ethnicity *(optional*)*: ◯ White ◯ Black ◯ American Indian/Alaska Native ◯ Asian/Pacific Islander ◯ Hispanic/Latino ◯ Other

**You are not required to answer. This information is important, however, as it helps us understand the diversity of our membership.*

D. DEPENDENT INFO

Please list all dependents who are enrolling in the Student Health Plan.

8a. Last _____ First _____ M.I. _____ SSN ***(Required)*** _____ Date of Birth _____

Rel: ◯ *Spouse* ◯ *Other* Sex: ◯ *M* ◯ *F* ◯ Disabled

Primary Language *(optional*)*: Spoken: _____ Written: _____

Ethnicity *(optional*)*: ◯ White ◯ Black ◯ American Indian/Alaska Native ◯ Asian/Pacific Islander ◯ Hispanic/Latino ◯ Other

8b. Last _____ First _____ M.I. _____ SSN ***(Required)*** _____ Date of Birth _____

Rel: ◯ *Son* ◯ *Daughter* ◯ Disabled

Primary Language *(optional*)*: Spoken: _____ Written: _____

Ethnicity *(optional*)*: ◯ White ◯ Black ◯ American Indian/Alaska Native ◯ Asian/Pacific Islander ◯ Hispanic/Latino ◯ Other

**You are not required to answer. This information is important, however, as it helps us understand the diversity of our membership.*

D. DEPENDENT INFO *Continued*

Please list all dependents who are enrolling in the Student Health Plan.

8c. Last _____ First _____ M.I. _____ SSN ***(Required)*** _____ Date of Birth _____

Rel: ◯ *Son* ◯ *Daughter* ◯ Disabled

Primary Language *(optional*)*: Spoken: _____ Written: _____

Ethnicity *(optional*)*: ◯ White ◯ Black ◯ American Indian/Alaska Native ◯ Asian/Pacific Islander ◯ Hispanic/Latino ◯ Other

8d. Last _____ First _____ M.I. _____ SSN ***(Required)*** _____ Date of Birth _____

Rel: ◯ *Son* ◯ *Daughter* ◯ Disabled

Primary Language *(optional*)*: Spoken: _____ Written: _____

Ethnicity *(optional*)*: ◯ White ◯ Black ◯ American Indian/Alaska Native ◯ Asian/Pacific Islander ◯ Hispanic/Latino ◯ Other

**You are not required to answer. This information is important, however, as it helps us understand the diversity of our membership.*

Note: Make sure you sign and date the application below.

E. SIGNATURE: AGREEMENT: I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge and that I have read the important information on the last page of this form.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

9. Subscriber's Signature: _____ 10. Date: _____

IMPORTANT INFORMATION

Failure to complete any sections will result in a processing delay of your application, member ID cards and, claims payment.

If you should have any questions about this Enrollment Application/Change Form, please call the CDPHP® member services department at (518) 641-3700 or 1-800-777-2273. Thank you for choosing CDPHP for your health care coverage.

Your signature on this application hereby affirms the following:

On behalf of myself and any dependents listed, I hereby apply for coverage under the Student Health Plan Contract issued by Capital District Physicians' Health Plan, Inc. and/or CDPHP Universal Benefits,® Inc. (CDPHP UBI), and/or Delta Dental of New York, Inc.

I understand that the benefits for which I (we) will be eligible are in accordance with those described in the Individual Contract and any attached riders. I further understand that for HMO benefits provided by Capital District Physicians' Health Plan, Inc., except for emergencies, covered services must be obtained through a participating physician (unless otherwise noted in rider) or in a participating hospital (unless otherwise noted in rider) when admitted or referred by a participating physician (unless otherwise noted in rider), and also that certain services may require a copayment (unless otherwise noted in rider) by me (or my dependents) directly to the provider of such services.

I understand that unresolved grievances are subject to the procedure specified in the Student Health Plan Contract.

CDPHP COMPANIES
Capital District Physicians' Health Plan, Inc.
CDPHP Universal Benefits,® Inc.
Capital District Physicians' Healthcare Network, Inc.

Pending approval by the New York State Department of Financial Services

Discrimination is Against the Law

Capital District Physicians' Health Plan, Inc. (CDPHP®) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. CDPHP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

CDPHP:

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

If you need these services, contact the CDPHP Civil Rights Coordinator.

If you believe that CDPHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: CDPHP Civil Rights Coordinator, 500 Patroon Creek Blvd., Albany, NY 12206, 1-844-391-4803 (TTY/TDD: 711), Fax (518) 641-3401. You can file a grievance by mail, fax, or electronically at https://www.cdphp.com/customer-support/email-cdphp. If you need help filing a grievance, the CDPHP Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD 1-800-537-7697).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Multi-language Interpreter Services

ATTENTION: If you speak a non-English language, language assistance services, free of charge, are available to you. Call the number on your member ID card (TTY: 711).

ATENCIÓN: Si habla otro idioma que no es el inglés, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que figura en su tarjeta de identificación de miembro (TTY: 711).

注意：如果您使用的語言不是英語，您可以免費獲得語言援助服務。請致電您會員 ID 卡上的電話（聽力障礙電傳：711）。

ВНИМАНИЕ: Если вы говорите на иностранном языке, вы можете воспользоваться бесплатными услугами перевода. Позвоните по номеру на вашей ID карточке участника (Телетайп: 711).

ATANSYON: Si ou pale yon lang ki pa Angle, wap jwenn sèvis asistans lang gratis disponib pou ou. Rele nimewo ki sou kat ID manm ou a (TTY: 711).

주의: 영어 이외의 언어를 사용하는 경우 무료로 언어 지원 서비스를 받을 수 있습니다. 귀하의 회원 ID 카드에 있는 번호로 전화하십시오(TTY: 711).

ATTENZIONE: Se non parla inglese né una lingua anglofona, sono disponibili servizi gratuiti di assistenza linguistica. Chiami il numero presente sulla scheda ID dei membri (TTY: 711).

אויפמערקזאם: אויב איר רעדט , זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון
אפצאל. רופט דעם נומער אויף אייער מעמבער ID קארטל (711:TTY)

মনোযোগ দিনঃ আপনি যদি ইংরেজি বহির্ভুত কোন ভাষায় কথা বলেন ,আপনার জন্য বিনা খরচায় ভাষা সহায়তা উপলভ্য রয়েছে। আপনার সদস্য আইডি কার্ডের নম্বরে কল করুন (TTY: 711)।

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer na Twojej członkowskiej karcie ID (TTY: 711).

تنبيه: إذا كنت تتحدث لغة غير الإنجليزية، تتوفر إليك خدمات مساعدة اللغة مجانًا. اتصل بالرقم الموجود
ببطاقة الهوية لعضويتك (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez au numéro indiqué sur votre carte de membre (ATS : 711).

توجہ دیں: اگر آپ انگریزی کے علاوہ دوسری زبان بولتے ہیں تو، آپ کے لیے زبان کی اعانت کی
خدمات مفت دستیاب ہیں۔ اپنے ممبر آئی ڈی کارڈ پر درج نمبر پر کال کریں (TTY: 711)۔

ATENSYON: Kung nagsasalita kayo ng wikang iba sa Ingles, magagamit niyo ang mga serbisyo sa tulong sa wika nang walang bayad. Tawagan ang numero sa inyong card miyembro ID (TTY: 711).

ΠΡΟΣΟΧΗ: Αν δεν μιλάτε Αγγλικά, υπάρχουν στη διάθεσή σας υπηρεσίες γλωσσικής υποστήριξης οι οποίες παρέχονται δωρεάν. Καλέστε τον αριθμό που θα βρείτε στην ατομική σας ταυτότητα μέλους (TTY: 711).

VINI RE: Nëse flisni një gjuhë jo-anglisht, shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Telefonojini numrit në kartën tuaj të ID të anëtarit (TTY: 711).