

# Employer Application Form

Please Print



Capital District Physicians' Healthcare Network, Inc.  
Capital District Physicians' Health Plan, Inc.  
CDPHP Universal Benefits,® Inc.  
500 Patroon Creek Blvd.  
Albany, NY 12206-1057  
(518) 641-5000 or 1-800-993-7299

This application is hereby made with CDPHP for enrollment of eligible members in accordance with the contract of the employer named below for coverage subject to the group meeting group eligibility.

Group Effective Date: \_\_\_\_\_ End Date: \_\_\_\_\_ Group ID: \_\_\_\_\_

Check all that apply:  Medical  Delta Dental  Self-Funded Rx

CDPHN-Administered Health Funding Arrangement(s):

Flexible Spending Account (FSA)  Health Reimbursement Arrangement (HRA)  Health Savings Account (HSA)  None

## EMPLOYER INFORMATION (Required)

1. Legal company name

Fed Tax ID \_\_\_\_\_ SIC code \_\_\_\_\_  
Street address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

2. Decision contact name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Street Address \_\_\_\_\_ ZIP \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ E-mail \_\_\_\_\_

3. Billing contact name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Street Address \_\_\_\_\_ ZIP \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ E-mail \_\_\_\_\_

4. Broker contact name \_\_\_\_\_ Broker agency \_\_\_\_\_  
Is this your broker of record?  Y  N

5a. Total number of employees on company payroll nationwide (include full-time, part-time, owners) \_\_\_\_\_  
b. Total number of employees eligible for health insurance (eligible employees must work a minimum of 20 hours a week) nationwide \_\_\_\_\_  
in CDPHP service area \_\_\_\_\_  
c. Eligible employees not enrolling in CDPHP: Covered through spouse \_\_\_\_\_ Covered under Medicare \_\_\_\_\_  
Opting out of insurance \_\_\_\_\_  
Enrolling in other insurance \_\_\_\_\_ (insurer: \_\_\_\_\_)

## CLASSIFICATION OF COVERED EMPLOYEES

The group agrees that membership enrollment applications will be submitted only for eligible employees subject to the enrollment provisions set forth in the contract and subject to the following eligibility guidelines. Member enrollment applications should be submitted no later than 30 days prior to the effective date.

6. Eligible employee definition (check one):  Full-time only  Full-time and part-time (20 hours or more)

## SUBGROUPS

## ENROLLMENT CLASS

7. Class description (i.e., hourly and salary employees): \_\_\_\_\_ Class #: \_\_\_\_\_  
Waiting period for new hire: \_\_\_\_\_  
Employer contribution % or \$ Single: \_\_\_\_\_ Employee + Spouse: \_\_\_\_\_ Parent + Child(ren): \_\_\_\_\_ Family: \_\_\_\_\_ Medicare: \_\_\_\_\_  
Non-Medicare retiree: \_\_\_\_\_ Employees will be terminated (check one):  End of month  Date of termination

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8. Class description (i.e., hourly and salary employees): \_\_\_\_\_

Waiting period for new hire: \_\_\_\_\_

Employer contribution % or \$ Single: \_\_\_\_\_ Employee + Spouse: \_\_\_\_\_ Parent + Child(ren): \_\_\_\_\_ Family: \_\_\_\_\_ Medicare: \_\_\_\_\_

Non-Medicare retiree: \_\_\_\_\_ Employees will be terminated (check one):  End of month  Date of termination

9. Is CDPHP sole medical carrier?  Y  N 9b. If no, list other carriers: \_\_\_\_\_  2nd open enrollment?

Date: \_\_\_\_\_

Have you ever had coverage through CDPHP before?  Y  N If yes, under what legal name? \_\_\_\_\_

**INTERNAL USE ONLY**

Rep code: \_\_\_\_\_ Broker #: \_\_\_\_\_ Parent group ID#: \_\_\_\_\_

Facets group type:  Employer Group  Individual  Chamber  Association  Sole Proprietor

Group size:  Large  Small  Individual  Sole Prop

Total replacement?  Y  N Send bill to:  Group  Subgroup  Broker

Special Instructions (billing requirements, additional locations, reporting requirements, etc.):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SIGNATURE AUTHORIZATION**

**MEDICARE:** A subscriber who is eligible for Medicare and employed by an employer group with fewer than 20 employees or a retiree for an employer with more than 20 employees, must have both Parts A and B of Medicare and attach a copy of his/her Medicare card to the enrollment application. Employers are not required to offer coverage to retirees.

**Please Note:** Benefits on your signed rate sheet are made a part of this application and may NOT be altered or modified until contract renewal, unless statutorily mandated. Requests for changes to this application must be made in writing. Employers are responsible for the administration of any continuation of coverage.

**Authorization:** 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 for the claim for each such violation.

Employer's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print name: \_\_\_\_\_

Employer's title: \_\_\_\_\_

Broker's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print name: \_\_\_\_\_

Account Rep's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print name: \_\_\_\_\_

Delta Dental Service Plans are underwritten and administered by Delta Dental of New York, Inc.



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