Crystal Run Health Plan, LLC
109 Rykowski Lane, Middletown, NY 10941

Individual HMO Plan Application and Change of Enrollment Form

A plan for better health... Crystal Run Health Plans

APPLICANT INFORMATION

Last Name	First Name		M.I.	Gender ☐Female ☐Male
Date of Birth *(MM/DD/YYYY)* / Social Security Number – –	Home Phone ( ) –		Daytime Phone ( ) –	
Marital Status ☐ Single ☐ Married ☐ Domestic Partner	E-Mail Address		Cell Phone ( ) –	
Street Address	Apt	City	State	Zip Code
Mailing Address (If **Not** The Same as Street Address)	Apt	City	State	Zip Code

QUALIFYING EVENT INFORMATION

Are you applying for new coverage? ☐ Yes ☐ No

If Yes, please choose the reason for this application:

☐ Open Enrollment ☐ Marriage

☐ Birth of a Child/Adoption ☐ Loss of Coverage

☐ Other (Please Explain): _____

Are you changing your current coverage? ☐ Yes ☐ No

If Yes, please choose the reason for this application:

☐ Termination ☐ Adding Dependent(s)

☐ Death ☐ Removing Dependent(s)

☐ Other (Please Explain): _____

Requested Effective Date of Enrollment or Change, if Applicable: _____ MM/DD/YYYY

PLAN SELECTION

Please Select Your Plan and Any Additional Riders: (Choose <u>One</u>)

☐ Bronze HMO Standard	☐ Silver HMO Standard	☐ Gold HMO Standard	☐ Platinum HMO Standard
☐ Bronze HMO Non-Standard	☐ Silver HMO Non-Standard	☐ Gold HMO Non-Standard	☐ Platinum HMO Non-Standard
☐ Bronze Child-Only Plan	☐ Silver Child-Only Plan	☐ Gold Child-Only Plan	☐ Platinum Child-Only Plan
☐ Catastrophic Plan	☐ Silver NS HDHP	☐ Gold NS HDHP	

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Have you obtained stand-alone dental coverage that provides a pediatric dental essential health benefit through a New York State of Health (NYSOH) certified stand-alone dental plan offered outside the New York State of Health marketplace?

☐ Yes ☐ No

If you answered "Yes", please provide the name of the company issuing the stand-alone dental coverage. If you answered "No", Crystal Run Health Plan, LLC will provide you coverage of the pediatric dental essential health benefit.

PCP SELECTION FOR SUBSCRIBER

Crystal Run Health Plan, LLC is an HMO. You and each dependent applying for coverage in the HMO must select a Primary Care Physician (PCP).

Physician (PCP) Name: _____

Provider ID/NPI: | | | | | | | | | |

Are you a current patient of this physician? ☐ Yes ☐ No

DEPENDENT INFORMATION

Spouse/Domestic Partner:

Last Name	First Name	M.I.	Gender
			☐Female ☐Male

Date of Birth *(MM/DD/YYYY)*	Social Security Number	Relationship to Subscriber:	
/ /	- -	☐ Spouse ☐ Domestic Partner	

Dependent 1:

Last Name	First Name	M.I.	Gender
			☐Female ☐Male

Date of Birth *(MM/DD/YYYY)*	Social Security Number	Relationship to Subscriber: ☐ Son ☐ Daughter ☐ Other _____	Is this dependent disabled? ☐ Yes ☐ No
/ /	- -		

PCP Selection For Dependent 1:

Crystal Run Health Plan, LLC is an HMO. You and each dependent applying for coverage in the HMO must select a Primary Care Physician (PCP).

Physician (PCP) Name: _____

Provider ID/NPI | | | | | | | | | |

Are you a current patient of this physician? ☐ Yes ☐ No

Other Coverage for Dependent 1:

Does this dependent have other medical insurance, including Medicare or Medicaid? ☐ Yes ☐ No

Type of Coverage: _____

Name of Insurer: _____

Effective Date: _____

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Dependent 2:

Last Name	First Name	M.I.	Gender
			☐Female ☐Male

Date of Birth *(MM/DD/YYYY)*	Social Security Number	Relationship to Subscriber:	Is this dependent disabled?
/ /	- -	☐ Son ☐ Daughter ☐ Other _____	☐ Yes ☐ No

PCP Selection For Dependent 2:

Crystal Run Health Plan, LLC is an HMO. You and each dependent applying for coverage in the HMO must select a Primary Care Physician (PCP).

Physician (PCP) Name: _____

Provider ID/NPI: | | | | | | | | | |

Are you a current patient of this physician? ☐ Yes ☐ No

Other Coverage for Dependent 2:

Does this dependent have other medical insurance, including Medicare or Medicaid? ☐ Yes ☐ No

Type of Coverage: _____

Name of Insurer: _____

Effective Date: _____

Dependent 3:

Last Name	First Name	M.I.	Gender
			☐Female ☐Male

Date of Birth *(MM/DD/YYYY)*	Social Security Number	Relationship to Subscriber:	Is this dependent disabled?
/ /	- -	☐ Son ☐ Daughter ☐ Other _____	☐ Yes ☐ No

PCP Selection For Dependent 3:

Crystal Run Health Plan, LLC is an HMO. You and each dependent applying for coverage in the HMO must select a Primary Care Physician (PCP).

Physician (PCP) Name: _____

Provider ID/NPI: | | | | | | | | | |

Are you a current patient of this physician? ☐ Yes ☐ No

Other Coverage for Dependent 3:

Does this dependent have other medical insurance, including Medicare or Medicaid? ☐ Yes ☐ No

Type of Coverage: _____

Name of Insurer: _____

Effective Date: _____

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Dependent 4:				
Last Name	First Name	M.I.	Gender ☐Female ☐Male	
Date of Birth *(MM/DD/YYYY)* / /	Social Security Number - -	Relationship to Subscriber: ☐ Son ☐ Daughter ☐ Other _____	Is this dependent disabled? ☐ Yes ☐ No	

PCP Selection For Dependent 4:

Crystal Run Health Plan, LLC is an HMO. You and each dependent applying for coverage in the HMO must select a Primary Care Physician (PCP).

Physician (PCP) Name: _____

Provider ID/NPI: | | | | | | | | | |

Are you a current patient of this physician? ☐ Yes ☐ No

Other Coverage for Dependent 4:

Does this dependent have other medical insurance, including Medicare or Medicaid? ☐ Yes ☐ No

Type of Coverage: _____

Name of Insurer: _____

Effective Date: _____

If you have additional dependents, please provide their information on a separate sheet of paper.

BROKER INFORMATION (IF APPLICABLE)

Broker:	
Last Name:	First Name:
Broker Identification Number:	Broker Email Address:
Broker Agency:	

AGREEMENT *(Please read carefully before signing.)*

I hereby apply for coverage on behalf of myself and any dependents listed above. I certify and agree that the information given on this application is current, true and complete to the best of my knowledge and belief. I understand that coverage will take effect only if a contract is issued and the first premium is paid in full. I understand that the benefits for which I/we are eligible are those described in the individual contract selected and any attached riders. I further understand that for HMO benefits, except for emergencies or as otherwise provided by the contract, all covered services must be obtained through a participating provider.

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.

Applicant's Signature _____ **Date** _____