MAILING ADDRESS: 109 Rykowski Lane, Middletown, NY 10941

IMPORTANT:

PLEASE PRINT AND PRESS DOWN FIRMLY WHEN COMPLETING THIS FORM.

IN ORDER TO PROCESS THE ATTACHED FORM AND BEGIN COVERAGE, ALL FIELDS MUST BE COMPLETED ACCURATELY AND IN ITS ENTIRETY.

-Use only blue or black ballpoint pen

-Enter all dates using the MM/DD/YYYY format

-Employer and employee signatures are required

-List any coordinating coverage (coverage in addition to this coverage)

-

-Attach disability paperwork, if applicable

-Check "young adult" in the child column if the child is under the age of 30, eligible, and enrolling onto the young adult option if selected by the group.

-Submit this form within 31 days of the requested effective date or within 60 days of the qualifying event for COBRA or State Continuation

If you have any questions,
please call customer service at
1-844-638-6506

Form: CRHIC LG/SG Member Enrollment Form (2015)

Crystal Run Health Insurance Company, Inc. "CRHIC"
Group Member Enrollment Form

MAILING ADDRESS: 109 Rykowski Lane, Middletown, NY 10941

A. Group Information (To be completed by the employer)				Please print neatly using black or blue ballpoint pen • ALL DATES MUST BE: MM/DD/YYYY
Group Number Group Name	Plan CSP Billing Group	Date of Hire / /	Effective Date / /	Occupation
☐On Leave of Absence ☐Union Employee ☐Retired ☐Disabled	COBRA/Young Adult/SC Qualifying Event	Event Date / /	employer signature X	Date / /
B. Applicant Details (To be completed by the employee)	Employee/Subscriber	spouse	child	child
Social Security Number:				
Last Name:				
First Name, Middle Initial:				
Date of Birth: (MM/DD/YYYY)	/ /	/ /	/ /	/ /
Gender and Disability Status: (Check appropriate boxes.)	☐M ☐F / ☐Disabled	☐M ☐F / ☐Disabled	☐M ☐F / ☐Disabled	☐M ☐F / ☐Disabled
Primary Care Physician (PCP) ID Number: PCP Name: (If an existing patient of PCP, check "Yes".)	☐Yes	☐Yes	☐Yes	☐Yes
Check all that apply:		☐Domestic Partner (if applicable)	☐Young Adult (if applicable) ☐	☐Young Adult (if applicable) ☐
C. Coordination of Benefits	Employee/Subscriber	spouse	child	child
Medicare Coverage — Check appropriate box and list effective date:	Part A / / Part B / / Part D / /	Part A / / Part B / / Part D / /	Part A / / Part B / / Part D / /	Part A / / Part B / / Part D / /
Pharmacy ☑Same for all — effective date: / / — Policy Number: / Carrier: / Policy Holder: / Group Number:	☐ BIN: PCN:	☐ BIN: PCN:	☐ BIN: PCN:	☐ BIN: PCN:
Medical ☐ Same for all — Policy Number: / Carrier: / Policy Holder: / Effective Date:	/ /	/ /	/ /	/ /

. I understand that my enrollment and benefits are in accordance with those described in the applicable CRHIC Certificate. . I authorize any health provider or insurer to furnish Crystal Run Health Insurance Company, Inc.. any records concerning me or any enrolled member of my family for whom information is requested. A photographic copy of this authorization shall be valid as the original.

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 five thousand dollars and the stated value of the claim for each such violation.

Employee's/Young Adult's address (apt #)	Employee's/Young Adult's Signature Date
City State Zip code — E-mail Address (optional) — Telephone:	X / /