NYSPFFA Dental Coverage Options

	Plan 1 — (Standard Plan)		Plan 2 — (High Plan)	
Brief Plan Description	100/80/50/50, 1000 max $50/$150 Ded		100/100/100/100, 1000 max $50/$150 Ded	
Dental Benefits	**In Network**	**Out-Network**	**In Network**	**Out-Network**
Annual Benefit Maximum	$1,000	$1,000	$1,000	$1,000
Maximum Carryover (Type A, B, C)	No	No	No	No
Orthodontic Lifetime Maximum	$2,000	$2,000	$2,000	$2,000
Reimbursement Schedule	Preferred	Preferred	Preferred	Preferred
Annual Deductible, Individual/Family				
Preventative	N/A	N/A	N/A	N/A
Basic	$50/150 Ded	$50/150 Ded	$50/150 Ded	$50/150 Ded
Major	$50/150 Ded	$50/150 Ded	$50/150 Ded	$50/150 Ded
Orthodontia	$50/150 Ded	$50/150 Ded	$50/150 Ded	$50/150 Ded
Coinsurance				
Preventative	100%	100%	100%	100%
Basic	80%	80%	100%	100%
Major	50%	50%	100%	100%
Orthodontia	50%	50%	100%	50%
Other Benefits				
Sealants Through	Age 17	Age 17	Age 17	Age 17
Fluoride Treatments Through	Age 19	Age 19	Age 19	Age 19
Dental Implants	Not Covered	Not Covered	Not Covered	Not Covered
Missing Tooth Coverage	Not Covered	Not Covered	Not Covered	Not Covered
Dependent Coverage				
Non-Student Through	Age 19 EOY	Age 19 EOY	Age 19 EOY	Age 19 EOY
Student Through	Age 23 EOY	Age 23 EOY	Age 23 EOY	Age 23 EOY
Monthly Premium*				
Single	**$32.79**		**$38.55**	
Member + Child	**$66.53**		**$79.68**	
Member + Spouse	**$63.97**		**$75.76**	
Family	**$108.01**		**$129.39**	

*All rates include $3 TPA administration fee

Coverages underwritten by EmblemHealth

Coverage effective 12/1/2019

EmblemHealth

Transaction Form for Group Accounts

I. SUBSCRIBER INFORMATION

Last Name	First Name	M.I.	Sex	Social Security Number

Street Address	Apt.	City	State	ZIP Code

Were you ever a member of EmblemHealth?
☐ NO ☐ YES
If YES, member ID ____________________

Marital Status:
☐ Single ☐ Married
☐ Domestic Partner (DP)

Birth Date:
Mo. Day Yr.

Home Tel. #: ____________________
Work Tel. #: ____________________
Cell Tel. # (see back of form*): ____________________

Email Address: ____________________

Applicant's hours worked per week:
☒ At least 20 hours ☐ Less than 20 hours ☐ COBRA
☐ Retiree (see back of form**)

Type of Coverage: ☐ Individual ☐ Family ☐ Employee & Spouse/DP ☐ Employee & Child

Note: If electing Young Adult Coverage, please submit a completed Young Adult Election Form.

Primary Care Physician Name: **(Not required for EPO/PPO members)** ____________________ ID Number: ____________________

OB/GYN Selection Name: **(Optional)** ____________________ ID Number: ____________________

Are you covered by any other health insurance or Medicare?
☐ NO ☐ YES If YES, indicate:
Insurance Co. Name: ____________________
Insurance Co. Telephone #: ____________________ Type of Coverage: ____________________
Policy #: ____________________ Effective Date: ____________________

Check One:
☒ New Enrollment
☐ Reinstatement
☐ Termination
☐ Change

Status:
☐ Add Dependent
☐ Remove Dep.
☐ Address Change
☐ Name Change

Transfer:
☐ To Another Carrier
☐ EmblemHealth Group Change:
From: ____________________
To: ____________________

II. ENROLLMENT INFORMATION — IF YOU ARE ENROLLING YOUR SPOUSE/DP AND/OR CHILDREN, PLEASE LIST EACH ONE BELOW — SEE ELECTION OF COVERAGE FOR ELIGIBILITY

Note: A birth/marriage certificate or 1040 Form will be required for spouse/dependents with different last name.

Last Name (if different)	First Name	Social Security Number	Sex	Relationship	Birth Date Mo.	Day	Yr.	✓ if Disabled[1]	Primary Care Physician Name/ID Number (Not required for EPO/PPO members)	OB/GYN Selection Name/ID Number (Optional)
DEPENDENT				☐ Spouse ☐ DP ☐ Child						
Current Health Insurance Information:	Carrier Name: ____________			Coverage Begin Date: ____________				Coverage End Date: ____________		
DEPENDENT				☐ Child						
Current Health Insurance Information:	Carrier Name: ____________			Coverage Begin Date: ____________				Coverage End Date: ____________		
DEPENDENT				☐ Child						
Current Health Insurance Information:	Carrier Name: ____________			Coverage Begin Date: ____________				Coverage End Date: ____________		

[1]For dependent adult children incapable of self-sustaining employment, please see Section A on the back side of this form to check the appropriate "Add Dependent" box, and follow the instruction for required documentation.

Your signature is required to process this form. Your signature attests that you have read the reverse side 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 material fact associated with such application commits a fraudulent insurance act. Such act is a crime, and will be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Applicant must sign here: ____________________ **Date:** ____________________

III. EMPLOYER INFORMATION — THIS SECTION TO BE COMPLETED BY EMPLOYER/CONTRACTOR GROUP

Name of Group: New York State Professional Firefighters Association

Group Number:

Sub Group ID ____________ Class ID ____________ Plan ID ____________

If you selected a small group metal plan, please indicate which plan you are selecting: ____________________

☐ HIP ☐ GHI ☐ HIPIC
Plan Name: ____________________

Requested Effective Date: Medical: N/A Dental: 12/1/2019

Hire Date:

Waiting Period:

Date Submitted:

Approved By: (Group Plan Administrator)

Instructions to Benefit Administrators or Group Representatives: For groups with 100 or fewer full-time equivalent eligible employees, you MUST complete Section A on the reverse side of this form. Required documentation MUST be attached to this Transaction Form to be processed.

IMPORTANT INFORMATION

1. The subscriber must complete sections I and II. The group plan administrator must complete section III, and if for a small group (100 or fewer full-time equivalent eligible employees) provide all necessary documentation.
2. All transactions are subject to EmblemHealth's retroactive enrollment period – members must be enrolled within 30 days (for small groups) or 90 days (for large groups) from the Qualifying Event.
3. As part of New York State's "Age 29" law, eligible young adults through age 29 may obtain coverage through a parent's group policy.
4. Failure to complete any part of this form (e.g., group number, reason for submission, certificate number, signature, etc.) will require EmblemHealth to return this transaction form to the employer group plan administrator and may delay the requested effective date of coverage.
5. Return the completed Transaction Form along with any required documentation to: Membership, PO Box 2820, New York, NY 10116-2820.

Get more information at **www.emblemhealth.com**.

SECTION A

(To be completed by Benefits Administrator)

ACTION Check (✔)One	Qualifying Event	Documentation Required
☐ Add Subscriber	New Hire or Change in Plan	For eligible employees who work at least 30 hours per week, provide a recent Copy of NYS-45 showing this subscriber as an employee or provide copy of payroll documentation reflecting the date, employee's name and Social Security #, or the employee's current-year W-4 Form.
☐ Add Spouse	Marriage	**If last name is different** ☐ Marriage Certificate ☐ 1040 Form
☐ Add Dependent	Birth or Adoption	**If last name is different** ☐ Birth Certificate ☐ Formal Adoption Papers ☐ Court-Approved Guardianship Papers
☐ Add Young Adult	Young Adult Coverage	Young Adult Election Form
☐ Add Dependent	Dependent Adult Child Incapable of Self-Sustaining Employment	Disability Status Request Form
☐ Add Spouse ☐ Add Dependent	Loss of Coverage	Certificate of Creditable Coverage
☐ Add Domestic Partner	Domestic Partnership	Declaration of Cohabitation & Financial Interdependence Form

Note: No exceptions to our retroactive enrollment period will be allowed. Small group members must be enrolled within 30 days from the Qualifying Event/next billing date (or within 90 days for large group members).

*I understand that the phone number(s) I provided on this form may be used by EmblemHealth or any of its contracted parties to contact me about my account, my health benefit plan or related programs, or services provided to me.

** Retiree option is applicable for large groups only.

Group Health Incorporated (GHI), Health Insurance Plan of Greater New York (HIP), HIP Insurance Company of New York (HIPIC), and EmblemHealth Services Company, LLC are EmblemHealth companies. EmblemHealth Services Company, LLC provides administrative services to the EmblemHealth companies.

TIMELY PAYMENT ADMINISTRATORS

Ph: 516-858-7298 | Fax: 516-795-4392

I(We) do hereby authorize Timely Payment Administrators hereafter named COMPANY, to initiate Recurring (debit) entries to (my/our) account indicated at the depository financial institution named below, hereafter named FINANCIAL INSTITUTION. I further authorize COMPANY to initiate an adjusting or correcting entry as necessary. Finally, should any such debit(s) be returned for any reason, I(we) authorize the COMPANY to collect such debt(s) electronically from the same account identified below.

What is the EFT plan?

- The EFT plan allows COMPANY to pay your policy premiums by automatically withdrawing funds from your FINANCIAL INSTITUTION account monthly.

How much will be deducted from my account?

- We will only deduct premium payments according to the payment schedule outlined in your policy plus an administrative fee.

How can I cancel the EFT plan?

- Call MBM Insurance Services, Inc at 516-795-8248 to request a cancellation form. Once we receive your request, we will cancel the plan within 7-10 business days.
- We may cancel the plan without notice if a withdrawal is not honored or 30 days after we provide written notice to you.

Please complete the information below:

Bank Name ________________________ Account Type: ☐ Checking ☐ Savings

Account Number ________________________ Bank Routing #__________________________________

RECURRING DEBITS

Payment Start Date: __________________ Amount: _______________ Number of Payments: **Continuous**

*charge will appear as "**NYSPFFA**"

This Authorization is to remain in full force and effect until the COMPANY has received a written cancellation form from me (or either of us) of its termination.

SIGNATURE ____ DATE ______________________

PRINTED NAME ____