Off Exchange

Add/Change/Termination Form
INDIVIDUAL

HEALTH REPUBLIC
INSURANCE OF NEW YORK

A. GENERAL INFORMATION

Member ID Number _____ Member Name _____ Date ____-____-____

B. TRANSACTION

	EFFECTIVE DATE	REQUIRED INFORMATION
❑ **Addition** Complete WHO, REASON and SECTION C	____-____-____	**WHO** ❑ Spouse ❑ Domestic Partner ❑ Civil Union ❑ Dependent(s) **REASON** ❑ Open Enrollment ❑ Loss of Coverage ❑ Birth/Adoption ❑ Marriage ❑ Civil Union ❑ Partnership ❑ Other _____
❑ **Information Change/Correction** ❑ Name ❑ Date of Birth ❑ SSN ❑ Address ❑ County ❑ Email ❑ Phone ❑ Gender	____-____-____	Last Name _____ First Name _____ M.I._____ Date of Birth ____-____-____ SSN_____ Address _____ City _____ State_____ Zip_____ County _____ Email _____ Phone _____ Gender ❑ Female ❑ Male
❑ **Change Plan**	____-____-____	New Plan Name _____ Tier _____
❑ **Termination**	____-____-____	**WHO** ❑ Self ❑ Spouse/Partner ❑ Dependent(s) ❑ NY Young Adult Member ID #_____ Member Name _____ **REASON** ❑ Left Employer ❑ Discontinuation of COBRA ❑ Switched Plans ❑ Discontinuation of NY Young Adult ❑ Other _____

C. DEPENDENT INFORMATION

	SPOUSE/DOMESTIC PARTNER/CIVIL UNION	NEW DEPENDENT	NEW DEPENDENT
Social Security Number			
Last Name			
First Name, Middle Intial			

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C. DEPENDENT INFORMATION *(continued)*

	SPOUSE/DOMESTIC PARTNER/CIVIL UNION		NEW DEPENDENT		NEW DEPENDENT	
Date of Birth (mm/dd/yy)	____-____-____		____-____-____		____-____-____	
Gender and Disability Status	❑ F ❑ M	❑ Disabled	❑ F ❑ M	❑ Disabled	❑ F ❑ M	❑ Disabled

D. COORDINATION OF BENEFITS

		SPOUSE	DEPENDENT	DEPENDENT
Medicare	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 ____-____-____
Pharmacy ❑ Same for all Effective Date ____-____-____	Policy Number Carrier Policy Holder Group Number	_____ _____ _____ _____ EIN _____ PCN _____	_____ _____ _____ _____ EIN _____ PCN _____	_____ _____ _____ _____ EIN _____ PCN _____
Medical ❑ Same for all	Policy Number Carrier Policy Holder Effective Date	_____ _____ _____ ____-____-____	_____ _____ _____ ____-____-____	_____ _____ _____ ____-____-____

All transactions are effective on the first day of the next month

The completed form must be signed and any required documentation sent to Health Republic Insurance of New York via one of the following methods:

Mail to:
Health Republic Insurance of New York
Attn: Pre-Enrollment
30 Broad St., 7th Floor
New York, NY 10004

Brokers – please email:
brokers@newyork.healthrepublic.us

Members or Group Administrators – please fax:
1-855-201-7829

If you have any questions please call our member services team at **888-990-5702.**

Policy Holder Signature _____ Date ____-____-____

Member Signature_____ Date ____-____-____