Vytra HEALTH PLANS

Large Group Membership Application

Vytra Health Plans Long Island, Inc.
Vytra Health Services, Inc.

A. Subscriber Information

Last Name	First Name	Middle Initial	Telephone No. (Home) (Work)	Fax No.

Address (Street No.)	City	State	Zip

B. Enrollment Information

Name *(Indicate if Last Name is different)*	Birth Date Mo/Day/Yr	Social Security No.	Check if over 19 and a Full-Time Student	Sex	PRIMARY CARE PHYSICIAN *Each Member must select a PCP* Name (See Provider Directory)	Provider #	Check if Current Patient	Ob/Gyn Selection *Optional For Female Members* Name (See Provider Directory)	Provider #
Your Last Name First M.I.									
Spouse First M.I.									
Dependent First M.I.									
Dependent First M.I.									
Dependent First M.I.									
Dependent First M.I.									

Other Insurance Information

☐ I decline dependent coverage for my spouse. ☐ I decline dependent coverage for all my other dependents.

Is your spouse employed? ☐ Yes ☐ No If Yes, where? _____ Daytime Telephone Number (_____) _____

Name of your previous insurance plan _____ Name of other insurance plan _____

Are you or any family members listed above covered by other health insurance? *(e.g. Employer, Union, Student Assoc., Group Plan, Medicare, Medicaid)*

If yes, please provide the name of member and name of other insurance plan(s).

Member Name	Other Plan(s)	Member Name	Other Plan(s)

D. Employer Information *Please complete all shaded areas*

Employer Name	Division	Employer Group No.	Date of Hire	Effective Date	Coverage: ☐ Single ☐ Two Person ☐ Family

Check one: ☐ Open Enrollment ☐New Hire ☐ Conversion	Check one: ☐ DIRECT ACCESS ☐ POS DIRECT ACCESS ☐HMO ☐ POS	Status Change: ☐ Name change ☐Address change ☐ Add dependent ☐ Remove dependent ☐Other Reason: _____

Enrollment

☐ I hereby apply for enrollment in Vytra Health Plans Long Island, Inc., which provides health maintenance organization benefits (For HMO use only).

☐ I hereby apply for enrollment in Vytra Health Plans Long Island, Inc., which provides health maintenance organization benefits. I also apply for coverage under a separate contract from Vytra Health Services, Inc. which provides health insurance. (For POS use only).

The information provided is true and correct to the best of my knowledge. I understand that my coverage and benefits may be affected by failure to provide complete and accurate information. In the event that a premium contribution is required of me, I agree to pay, in advance the premium amounts applicable for the contract under which I am covered. I authorize the employer identified above to deduct from payroll such applicable premium amounts and to remit them to Vytra.

I understand and agree that my employer may discuss my health care coverage with Vytra and provide you with information regarding the coverage and benefits I had with them.

I consent to the use of all medical information relative to my care or that of any member of my family, except psychotherapy notes, by Vytra Health Plans for purposes of payment of benefits, treatment decisions and health care operations.

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 is subject to a civil penalty not to exceed the limits defined in the Insurance Law and the stated value of the claim for each such violation.

SIGNATURE	DATE

For Vytra Use Only

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The information provided in this application will be kept confidential.