



## SmartStart Membership Application

Vytra Health Services, Inc.

Subscriber Information									
Last Name	First Name	Middle Initial	Telephone No.	Home	Work	Fax No.			
Address (Street No.)		City	State	Zip Code	E-mail Address			<input type="checkbox"/> Male <input type="checkbox"/> Female	

While enrolled in Vytra, will you or any member of your family be covered by any other medical plan? Name of Contract Holder \_\_\_\_\_

Other Insurance (Name of Insurance) \_\_\_\_\_ Ins. ID# \_\_\_\_\_    None   End Stage Renal Disease    Yes  
 Social Security Disability Medicare    Part A ID# \_\_\_\_\_    Part B ID# \_\_\_\_\_    Individual Coverage    Family Coverage

Enrollment Information									
Name <i>Indicate if Last Name is different</i>	Birth Date <i>Mo/Day/Yr</i>	Social Security No.	Sex	Full Time Student Over 19	Former Health Coverage <i>(Previous 12 months)</i>	Dates of Former Coverage <i>From To</i>	Primary Hospital Name <i>(See selections below)</i>	Hospital ID# <i>(See selections below)</i>	Disabled
Your Last Name    First    M.I.				<input type="checkbox"/> Y <input type="checkbox"/> N					<input type="checkbox"/> Y <input type="checkbox"/> N
Spouse				<input type="checkbox"/> Y <input type="checkbox"/> N					<input type="checkbox"/> Y <input type="checkbox"/> N
Dependent				<input type="checkbox"/> Y <input type="checkbox"/> N					<input type="checkbox"/> Y <input type="checkbox"/> N
Dependent				<input type="checkbox"/> Y <input type="checkbox"/> N					<input type="checkbox"/> Y <input type="checkbox"/> N
Dependent				<input type="checkbox"/> Y <input type="checkbox"/> N					<input type="checkbox"/> Y <input type="checkbox"/> N
Dependent				<input type="checkbox"/> Y <input type="checkbox"/> N					<input type="checkbox"/> Y <input type="checkbox"/> N

Hospital Name    Hospital ID#	Hospital Name    Hospital ID#	Hospital Name    Hospital ID#	Hospital Name    Hospital ID#
Brookhaven Memorial Hospital    C006	New Island Hospital    C019	South Nassau Communities Hospital    C005	Good Samaritan Hospital    C008
Good Samaritan Hospital    C008	St. Catherine of Siena Hospital    C84360	Winthrop University Hospital    C001	Mercy Medical Center    C021
Mercy Medical Center    C021	St. Charles/J.T. Mather Hospitals    C84467		

I decline dependent coverage for my spouse.    I decline dependent coverage for my other dependents.   Have you or any of your dependent(s) ever been a member of Vytra before?    Yes    No  
 If yes, indicate the former employer and your name *(if different from shown)* \_\_\_\_\_

Employer Information <i>Please complete all shaded areas</i>						
Employer Name	Group No.	Date of Hire	Effective Date	Employer Waiting Period	Telephone No.	
Address	City	State	Zip Code	Check one: <input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire <input type="checkbox"/> Status Change <i>(see below)</i> <input type="checkbox"/> Conversion <i>(Direct Pay)</i>		

Enrollment	
<p><input type="checkbox"/> I hereby apply for enrollment in Vytra Health Services, Inc. which provides health insurance for myself and the eligible dependents listed above. 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.</p> <p>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.</p> <p>I understand that coverage is not included for a pre-existing condition during a 12 month waiting period, or lesser period if eligible for credit for previous coverage. 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.</p> <p>I authorize all medical information relative to my care or that of any member of my family to be released to Vytra Health Plans for all purposes.</p> <p><b>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.</b></p>	<p>Status Change:   <input type="checkbox"/> Add dependent   <input type="checkbox"/> Remove dependent                                    <input type="checkbox"/> Address Change   <input type="checkbox"/> Name Change</p> <p>Reason: _____</p> <hr/> <div style="border: 1px solid black; padding: 5px;"> <p style="text-align: center; margin: 0;"><b>For Vytra Use Only</b></p> <p style="margin: 5px 0;">Is applicant currently working at least 20 Hours/Week?   <input type="checkbox"/> Yes   <input type="checkbox"/> No</p> </div>
Applicant Signature	Date
Employer Signature <i>(Employer must cosign)</i>	