



NOTICE OF ELECTION FORM

NEW YORK MEDICAL COLLEGE

PLEASE RETURN THIS FORM TO:
Empire Blue Cross Blue Shield
85 Crystal Run Rd., Middletown NY 10941-7004
Attn: Membership and Billing Dept.

(Please print clearly or type)

GROUP ADMINISTRATOR COMPLETES

Type of Activity:

- New Enrollment, Group Change, Address Change, Termination, Family Status Change, Other - Please Explain

Date this form prepared: Month Day Year
EFFECTIVE DATE OF ENROLLMENT, CHANGE OR TERMINATION: Month Day Year

CHECK ONE:

- Active Employee, Pre-65 Retiree, COBRA

Group Number: 295617 Subgroup Number:
Package Code: Unit Number: N/A at this time
Authorized Signature:

MEMBER COMPLETES

Employee Information

Social Security Number
Last Name First Name MI
Street Apt No.
City State Zip Code
Sex: Male Female Date of Birth: (mmddyyyy) Type of Contract: Individual Family 2 Person

Surviving Spouse Deceased SSN

Dependent Information

Social Security Number List last name only if different from Employee
First Name MI Last Name
Sex: Male Female Relationship: Spouse Son Daughter Date of Birth: (mmddyyyy)
Full Time College Student? YES NO Medicare Disabled? YES NO

Social Security Number List last name only if different from Employee
First Name MI Last Name
Sex: Male Female Relationship: Spouse Son Daughter Date of Birth: (mmddyyyy)
Full Time College Student? YES NO Medicare Disabled? YES NO

Social Security Number List last name only if different from Employee
First Name MI Last Name
Sex: Male Female Relationship: Spouse Son Daughter Date of Birth: (mmddyyyy)
Full Time College Student? YES NO Medicare Disabled? YES NO

I hereby certify that the information I have provided on this form is true and accurate:

Employee Signature: Date: