



Initial Enrollment   
Change

**PARTICIPANT ENROLLMENT/CHANGE APPLICATION**

**Participant Information:**

Last Name		First Name		Initial	Social Security Number
Street Address				County	
City		State	ZIP Code	Telephone Number	
<input type="checkbox"/> Female	<input type="checkbox"/> Male	Date of Birth	Marital Status	Email Address	

If this is an Enrollment – List ALL eligible dependents to be enrolled. If this is a Change to existing coverage – List ONLY those dependents that are to be added or deleted.

Last Name (If Different)	First Name	Social Security #	Date of Birth	Relationship	Is Dependent a Student?	Is Dependent Disabled?
			/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Is Spouse Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Spouse's Name	SSN: DOB:	If Spouse employed, name & address of employer
Do you, your dependent(s) or spouse have other <b>Group Coverage or Medicare?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, name/address of Carrier: Medical/RX <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> RX <input type="checkbox"/> Name of Insured: <input type="checkbox"/> Individual <input type="checkbox"/> Family Coverage	

**Previous Health Care Coverage**

Previous Employer: \_\_\_\_\_ Dates of Coverage  
From: \_\_\_\_\_  
Please submit the certificate of creditable coverage to APA Partners, Inc., 13 British American Blvd., To: \_\_\_\_\_  
PO Box 1506, Latham, NY 12110. Please request the form from your previous carrier.

**Student Status**

Name(s) of enrolled student(s) \_\_\_\_\_ Accredited School/University \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medical**

**Dental**

**Vision**

SELF  2-PERSON  FAMILY  SELF  2-PERSON  FAMILY  SELF  2-PERSON  FAMILY

Check all that apply:  New Enrollment  Add Dependent(s) Qualifying Event \_\_\_\_\_  
 Cancel Dependent(s)  Name Change and Date \_\_\_\_\_  
 Address Change  Termination of Benefits  
 Request ID Card

**All information is true, accurate, and complete to the best of my knowledge.**  
Participant Signature X \_\_\_\_\_ Date \_\_\_\_\_

**Employer Information:**

Name of Employer:	Group Number:	Plan Number:	Date of Hire:
Special Comments:			

**TO BE COMPLETED BY EMPLOYER**

Is employee actively working full-time?  Yes  No Retired?  Yes  No Date of retirement: \_\_\_\_\_  
Effective Date: \_\_\_\_\_

Employer Authoring Signature \_\_\_\_\_

Mail To: APA Partners, Inc.  
P.O. Box 66601  
Albany, NY 12206