



**AGE 29 CONTINUATION OF COVERAGE
DIRECT PAY ENROLLMENT FORM**
(Please print & complete in full to avoid any delays)

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New York, NY 10006
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PART 1: SUBSCRIBER INFORMATION (PARENT OR GUARDIAN)

Subscriber First Name	Subscriber Last Name
Subscriber Atlantis Member ID	

PART 2: DEPENDENT'S INFORMATION

Dependent First Name		Dependent Last Name	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate (MM/DD/YYYY)	Social Security Number	
Other Current Health Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes: Name of Insured	Name of Carrier and Insurance Policy Number	
Prior Health Insurance <input type="checkbox"/> Yes* <input type="checkbox"/> No	Effective Date	Term Date	Name of Previous Carrier and Insurance Policy Number

***If you answered YES, you must submit proof of coverage, "Certificate of Creditable Coverage", which is issued by your previous Carrier. If you do not provide proof of coverage, you will be subject to pre-existing condition exclusions.**

PART 3: TYPE OF ACTIVITY

Section 1 - Additions

Effective Date

____ / ____ / ____

Add Dependent through Make Available Election - AHP-RIDER-MA29

____ / ____ / ____

Add Dependent through Young Adult Election

Election Event

During Annual Open Enrollment

Within 30 days prior to/following reaching max age

Within 30 days after eligibility for qualifying reasons

Section 2 - Deletions

____ / ____ / ____

Remove Dependent through Make Available Election - AHP-RIDER-MA29

____ / ____ / ____

Remove Dependent through Young Adult Election

Reason(s) _____

PART 4: SIGNATURE

I have read the information regarding this benefit option and agree to the terms and conditions of enrollment. I understand that In the absence of creditable coverage Pre-existing Medical Conditions may not be covered for 12 months from the initial enrollment date. I attest that the information I have supplied in this application is true and complete. I further understand that any person who knowingly with intent to defraud any insurance 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 material fact thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed \$5,000 and that stated value of the claim for each such violation.

SUBSCRIBER SIGNATURE: _____

DATE: _____

DEPENDENT SIGNATURE: _____

DATE: _____