1.01.12 - 3.15.12 New/Existing Groups Only

Enrollment / Change Form

_____/_____/_____

New/Existing Groups Effective: 1st or 15th of the Month Only

HealthPass
7120 Lake Ellenor Drive
Orlando, FL 32809-5721
Member Services: (888) 313-7277
Billing: (888) 313-7010
Fax: (888) 354-7277
Email: forms@healthpass.com

Enrollment / Additions
- ❒ Group Open Enrollment
  - ❒ Medical ❒ Dental ❒ Vision ❒ EverGuard
- ❒ New Employee
- ❒ Status Change (PT to FT) on ___/___/___
- ❒ Involuntary loss of coverage ___/___/___
- ❒ Add Dependent
  - ❒ Birth on ___/___/___
  - ❒ Marriage on ___/___/___
  - ❒ Adoption (Attach Legal Document)
- ❒ Other (describe) _____

Terminations / Changes
- ❒ Voluntary ❒ Involuntary
  - ❒ Medical ❒ Dental ❒ Vision ❒ EverGuard
- ❒ Cancel Dependents listed below in Section D
- ❒ **Changes: Check off below and fill in sections C&J.**
  - ❒ New Street Address
  - ❒ New Home Phone
  - ❒ New Name
- ❒ Other _____

Continuation-of-Coverage / COBRA
IMPORTANT! Payment required for activation of COBRA coverage. Remit with form directly to HealthPass.
- ❒ Employee Election
- ❒ Dependent(s) Election

Start date _____/_____/_____

Qualifying Event & Date
Involuntary
- ❒ Termination/Laid off

Voluntary
- ❒ Death of Covered Employee _____
- ❒ Dependent Child Aged Out _____
- ❒ Divorce of Covered Employee _____

A Waiving Coverage (complete Sections A, C, J and K) Check off plan(s) you are waiving:

By waiving coverage, I understand I will not be able to enroll without a qualifying event until my employer's next open enrollment.

❒ Health / Reason: ❒ Covered by other plan ❒ Not interested – no other coverage

Name of Insurer	Name of Policyholder	Policy ID#	Effective Date
/	/	/	/

❒ Dental / Reason: ❒ Covered by other plan ❒ Not interested – no other coverage

❒ Vision / Reason: ❒ Covered by other plan ❒ Not interested – no other coverage

B Prior Coverage

Failure to indicate prior coverage may result in claims issues.

Name of Insurer	Name of Policyholder	Policy ID#	Effective Date	Term Date
/	/	/	/	

C Employee Information

All information must be provided for enrollment.

Are you an owner of the company? ❒ Yes ❒ No

Company Name | Date of FT Hire | Hrs. Worked Per Week | ❒ Actively at Work ❒ Retired

Employee Name (Last, First, Middle Initial – PLEASE PRINT) | Social Security # | ❒ Male ❒ Female

Street Address | Apt # | City | State | Zip

Home/Cell Phone ( ) | Business Phone ( ) | Birth Date (MM/DD/YY) | ❒ Single ❒ Married ❒ Divorced

If you are selecting a plan from CompreHealth or the Oxford Liberty HMO please also select a primary care physician.

Dr. Name: ID#

D Dependent Information

List all Dependents (Last Name, First, Middle Initial)

Spouse* (Last, First, Middle Initial) ❒ M ❒ F Birth Date (MM/DD/YY) Social Security #

Dr. Name: ID#

Dep # 1 (Last, First, Middle Initial) ❒ M ❒ F Birth Date (MM/DD/YY) Social Security #

Dr. Name: ID#:

Dep # 2 (Last, First, Middle Initial) ❒ M ❒ F Birth Date (MM/DD/YY) Social Security #

Dr. Name: ID#:

Dep # 3 (Last, First, Middle Initial) ❒ M ❒ F Birth Date (MM/DD/YY) Social Security #

Dr. Name: ID#:

*Spouses enrolling under a different last name must provide a copy of their marriage certificate. Domestic Partner Coverage offered through all carriers. See eligibility guidelines.

All provider changes must be done through the carrier directly.

Online form(s) available at www.healthpass.com

E Type of Medical Coverage: ❒ Employee Only ❒ Employee and Spouse ❒ Employee and Child(ren) ❒ Family

❒ Please check if enrolling a Domestic Partner

F Medical Plan Options

	In-Network Only	Cost-Sharing
EmblemHealth	❒ EH EPO 40-10001K/50%-New ❒ CompreHealth HMO 30/50-1000 ❒ CompreHealth HMO 30/50-1000 G (CompreHealth is for NY residents only, network is limited to 5 Boroughs, Long Island , and Westchester)	❒ EH EPOcs 40-2500 1K/50%
HIP HEALTH PLAN OF NEW YORK	Not Available	❒ HP EPOcs 30/50-1500 New ❒ HIP PPOcs 30/50-2000/2500
UnitedHealthcare OXFORD	❒ Ox Freedom EPO 50-500(2500max) ❒ Ox Liberty HMO 30/50-500(1000max)	❒ Ox Liberty EPOcs 25/50-2000 ❒ Ox Liberty PPOcs 25/40-1000/2000 ❒ Ox USA PPOcs 25/40-1000/2000

G Dental Plan Options **Note: If your employer is offering Dental coverage, please indicate the coverage(s) desired. Effective date 1st of month only.**

GUARDIAN

❒ Managed DentalGuard (DMO) ❒ DentalGuard Preferred (PPO)

❒ Managed DentalGuard Plus (DMO) ❒ DentalGuard Preferred Plus (PPO)

❒ Employee Only ❒ Employee and Spouse ❒ Employee and Child(ren) ❒ Family

❒ Please check if enrolling a Domestic Partner

Please select Dental Facility ID# at initial enrollment only for DMO Coverage:

Employee:_____ Spouse/Domestic Partner: _____ Dep.#1:_____ Dep.#2:_____ Dep.#3:_____

H Vision Plan Option **Note: This is a 24 month contract based on your group's effective date. Coverage can only be cancelled at the completion of 2 years or if all HealthPass coverage is cancelled. Effective date 1st of month only.**

GUARDIAN

❒ I am electing VisionGuard

❒ Employee Only ❒ Employee and Spouse ❒ Employee and Child(ren) ❒ Family

❒ Please check if enrolling a Domestic Partner

I EverGuard Plan Options **Note: You may only elect the coverage level offered by your employer. If electing coverage, please indicate beneficary(ies). Available to employees only (no dependents).**

GUARDIAN

❒ I am electing EverGuard ❒ I am electing EverGuard *Plus*

Select up to two beneficiaries. Indicate the percent of life insurance proceeds for each beneficiary. Must total 100%.

Beneficiary Name / Relation / Percent

#1: / / %

Beneficiary Name / Relation / Percent

#2: / / %

J Employee Signature

I hereby apply for the health insurance company and benefit plan selected, understanding all benefits and coverage as specified in the enrollment materials and agreeing to abide by all the rules and regulations therein specified. I certify that I am actively at work a minimum of 20 hours per week and will notify HealthPass if my employment status changes. I elect to enroll myself and the family members indicated on this form with the medical and dental plans and primary care provider as indicated on this form. I certify that all dependents listed on this form are eligible for coverage under the terms of the plan documents. I agree to notify my employer within 30 days when such eligibility ceases. I understand the medical or dental plans have no liability to provide coverage for ineligible dependents. On behalf of myself and all family members, I hereby authorize all physicians, nurses, hospitals and other providers who or which have at any time, either before or after we became covered by the health insurance company, provided any diagnosis, treatment or any other service to any of us, to furnish the insurance companies or their authorized representative all information and records relating thereto. A photocopy or digital image of this authorization shall be considered as valid as the original. I understand that the Participating Providers, if any, do not necessarily include all types of doctors or providers.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. See eligibility guidelines. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. If I am required to contribute premium toward my coverage, I hereby authorize my employer to deduct such contributions in advance from wages due me and remit same to HealthPass. (The subscriber is responsible for the total cost of care received or for drugs purchased which are not authorized by the plan.)

"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 shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

I have carefully read this section and certify that all information provided on this form is true and complete to the best of my knowledge.

Employee Signature_____ Date _____

K Employer Signature **Form must be signed and dated by an Authorized Company Representative.**

I certify that the person(s) presented on this form are eligible employees (or dependents) and work for the employer identified on this form.

Signature_____ Date_____ HealthPass Group #_____

Authorized Company Representative (if enrolled)

HealthPass Use Only: Accepted by_____