**Employee Health Benefits Enrollment/Change Form**

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| **Section 1. Enrollee Information** |
| **Last Name:** | **First Name:** | **Middle Initial:** | **Date of Birth:** | **Gender:****□ Male** **□ Female****□ Transgender** | **Enrollment/Change Reason:**□ **Initial Enrollment** □ **Open Enrollment** □ **Enrollment Addition/Change:** □**Marriage** □**Newborn** □**Adoption** □**Retirement** □**Medicare Eligible** □**Loss of Coverage** □**Remove dependent**□**Remove Dependent** |
| **Street Address and Apt. Number:** | **City/ State/Zip:** | **Marital Status:****□ Single □ Married** **□ Legally Separated** **□ Divorced** | **If Medicare eligible, please indicate which apply:****□ 65+ □ Disability □ End Stage Renal Disease** |
| **Mobile/Home Phone Number:****Work Phone Number:** | **Personal Email Address:****Work Email Address:** | **Medicare Number (if applicable):****Medicare Effective Date:** | **□ Medicare Part A Coverage****□ Medicare Part B Coverage**  |
| **Marital Status and Effective Date:****□ Single □ Married □ Divorced □ Domestic Partner □ Legally Separated****Date of Event: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |
| **Are you presently employed elsewhere? □** Yes □ No**Do you have medical coverage through your other employer? □** Yes □ No**Do you have dental coverage through your other employer? □** Yes □ No**Do you have vision coverage through your other employer? □** Yes □ No**Do you have Medicare as primary coverage? □** Yes □ No | **Please Provide Employer Name:** | **Name of Carrier/Administrator/Policy Number:** |
| **Do you have other medical coverage with a previous employer?** □ Yes □ No**Do you have other dental coverage with a previous employer?** □ Yes □ No**Do you have other vision coverage with a previous employer?** □ Yes □ No**Do you wish to make Medicare your primary coverage? □** Yes □ No  | **Please Provide Previous Employer Name:** | **Name of Carrier/Administrator/Policy Number:** |
| **Section 2. Benefits Selection -Please make your benefits election and check one box for each line.** |
| **Medical & Dental Coverage Level:****Vision Coverage Level:** | **□ Employee □ Employee+ Spouse/DP □ Employee + Child(ren) □ Family □ Waive Coverage****□ Employee □ Employee+ Spouse/DP □ Employee + Child(ren) □ Family □ Waive Coverage** |
| **Section 3. Employee Signature** |
|  □ I certify that I am electing coverage as an employee, or former employee, retiree, current or former dependent of an active employee, or retiree, and am eligible for group coverage under the terms and conditions of the group’s contract. I make this election on behalf of all eligible dependents and myself. I understand that I am under a continuing obligation to notify the group of a change in my, or my dependent’s, status; such change may result in a change of insurance status with carrier(s) and that failure to make such notification may result in cancellation of coverage. I understand that if I become Medicare eligible while I am covered under this contract, any benefits I am entitled to under this contract will be reduced by any amounts paid by Medicare for those services, whether or not I apply for or submit a claim to Medicare. I authorize any health care provider, health care payor or government agency to furnish to carrier(s) or its designee all records pertaining to medical history, services rendered, and payments made regarding me or my dependents for use by carrier(s) to administer the terms of my health benefits contract. I also authorize carrier(s) to disclose such information to a carrier(s) designee my PCP and other providers, other payers, and the group contract holder, for purposes of continuity of care and medical management, disease management, health benefits contract administration, financial audits, and as otherwise required by law. The authorization in the foregoing sentence is valid for a maximum period of 24 months. If your coverage remains in effect upon the expiration of 24 months from the date of this enrollment form, you may be required to reauthorize carrier(s) or its designees to furnish all such records as described in this paragraph to the parties and for the purposes described in this paragraph for an additional authorization period. All statements and answers in this notice of election are true and are representations made to induce the issuance of the coverage. Any material misrepresentation may result in cancellation of coverage. I certify each Social Security Number and all information submitted is correct. If a qualifying event occurs, I will notify my employer within 30 days of the change. For the benefits I have selected, I authorize my employer to make the required deductions. I also reserve the right to terminate those benefits that require a payroll deduction at any time. **Insurance Fraud Statement: Any person who knowingly and with intent to defraud an 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 material fact there to, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim or each such violation.** **Employee Signature: Date:**  |
| **HR USE ONLY****Reviewed and entered by: Date: Coverage Effective Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **Section 4. Spouse/Domestic Partner** |
| **Last Name:** | **First Name:** | **Middle Initial:** | **Date of Birth:** | **Gender:** □ Male □ Female □ Transgender  |
| **Medicare Number (if applicable):** | **Medicare Part A Effective Date:** | **Medicare Part B Effective Date:** | **Disabled:**□ Yes □ No | **Date of Disability:** |
| **Employment Status:**□ Active □ COBRA □ Retiree  | **Name of Employer (If applicable):** | **Employer Group medical coverage?:** □ Yes □ No**Employer Group dental coverage?:** □ Yes □ No**Employer Group vision coverage?:** □ Yes □ No |
| **Type of Benefits & Coverage:** | **Name of Carrier/Administrator/Coverage Level:** | **Effective Date:** | **Cancellation Date:** |
| Vision □ Individual  | Coverage Level: □ Employee □ Employee+ Spouse/DP □ Employee + Child(ren) □ Family  |  |  |
| **Section 5. Dependent Information** |
| **Last Name:** | **First Name:****Middle Initial:** | **Email Address (Age 18 or older only):** | **Date of Birth:** | **Gender:**□ M □ F □ Transgender | **Relationship:** |
| **Social Security Number:** | **Full-time College Student:**□ Yes □ No | **Employment Status:**□ Active □ COBRA □ Retiree  | **Other coverage?** □ Medical Coverage □ Dental Coverage □ Vision Coverage □ None |
| **Name of Carrier/Administrator:** | **Effective and/or Termination Date:****Will coverage remain active: □ Yes □ No** | **Disabled:**□ Yes - Disability Date:\_ /\_ /\_ □ No | **Medicaid Number** **(if applicable):** | **Medicaid Effective Date:** |
| **Last Name:** | **First Name:****Middle Initial:** | **Email Address (Age 18 or older only):** | **Date of Birth:** | **Gender:**□ M □ F □ Transgender | **Relationship:** |
| **Social Security Number:** | **Full-time College Student:**□ Yes □ No | **Employment Status:**□ Active □ COBRA □ Retiree  | **Other coverage?**□ Medical Coverage □ Dental Coverage □ Vision Coverage □ None |
| **Name of Carrier/Administrator:** | **Effective and/or Termination Date:****Will coverage remain active: □ Yes □ No** | **Disabled:**□ Yes - Disability Date: /\_ /\_ □ No | **Medicaid Number** **(if applicable):** | **Medicaid Effective Date:** |
| **Last Name:** | **First Name:****Middle Initial:** | **Email Address (Age 18 or older only):** | **Date of Birth:** | **Gender:**□ M □ F □ Transgender | **Relationship:** |
| **Social Security Number:** | **Full-time College Student:**□ Yes □ No | **Employment Status:**□ Active □ COBRA □ Retiree  | **Other coverage?** □ Medical Coverage □ Dental Coverage □ Vision Coverage □ None |
| **Name of Carrier/Administrator:** | **Effective and/or Termination Date:****Will coverage remain active: □ Yes □ No** | **Disabled:**□ Yes - Disability Date:\_ /\_ /\_ □ No | **Medicaid Number** **(if applicable):** | **Medicaid Effective Date:** |
| **Last Name:** | **First Name:****Middle Initial:** | **Email Address (Age 18 or older only):** | **Date of Birth:** | **Gender:**□ M □ F □ Transgender | **Relationship:** |
| **Social Security Number:** | **Full-time College Student:**□ Yes □ No | **Employment Status:**□ Active □ COBRA □ Retiree  | **Other coverage?** □ Medical Coverage □ Dental Coverage □ Vision Coverage □ None |
| **Name of Carrier/Administrator:** | **Effective and/or Termination Date:****Will coverage remain active: □ Yes □ No** | **Disabled:**□ Yes - Disability Date:\_ /\_ /\_ □ No | **Medicaid Number** **(if applicable):** | **Medicaid Effective Date:** |
| **Section 6. Cancellation of Coverage** |
| **Requested Date for Cancellation of Coverage:** | **Reason for Cancellation of Spouse/Dependent Coverage:**□ Death □ Divorce □ Dependent no longer eligible □ Other, state reason………………………………………………………………………………………………………………………………………………………………………… |