



# Enrollment / Change Form

\_\_\_\_ / \_\_\_\_ / \_\_\_\_

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

## HealthPass

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### Enrollment / Additions

- Group Open Enrollment
  - Medical  Dental  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  EverGuard
- Cancel Dependents listed below in Section D
- Changes: Check off below and fill in sections C&I.**
  - 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 **To waive coverage, complete Sections A, C, I, and J.**

- Waive Health**  I am waiving health coverage. I understand I will not be able to enroll without a qualifying event until my employer's next open enrollment. Reason:  Covered by other plan  Not interested - no other coverage
- Waive Dental**  I am waiving the following Dental coverage:  Myself  Spouse  Child(ren)
- Name of Insurer \_\_\_\_\_ Name of Policyholder \_\_\_\_\_ Policy ID# \_\_\_\_\_ Effective Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### **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.

**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
	<input type="checkbox"/> EH EPO 40-10001K/50%-New <input type="checkbox"/> CompreHealth HMO 30/50-1000 <input type="checkbox"/> CompreHealth HMO 30/50-1000 G <small>(CompreHealth is for NY residents only, network is limited to 5 Boroughs, Long Island, and Westchester)</small>	<input type="checkbox"/> EH EPOcs 40-2500 1K/50%
	Not Available	<input type="checkbox"/> HP EPOcs 30/50-1500 <input type="checkbox"/> HIP PPOcs 30/50-2000/2500
	<input type="checkbox"/> Ox Freedom EPO 50-500(2500max) <input type="checkbox"/> Ox Liberty HMO 30/50-500(1000max)	<input type="checkbox"/> Ox Liberty EPOcs 25/50-2000 <input type="checkbox"/> Ox Liberty PPOcs 25/40-1000/2000 <input type="checkbox"/> 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.**



- Managed DentalGuard (DMO)  DentalGuard Preferred (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 EverGuard Plan Option Note: You may only elect the coverage level offered by your employer. If electing coverage, please indicate beneficiary(ies). Available to employees only (no dependents).**



- 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	Beneficiary Name	Relation	Percent
#1: _____	/	%	#2: _____	/	%

**I 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 \_\_\_\_\_

**J 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)