Enrollment/Change Form

New & Existing Groups
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www.healthpassny.com

A. Enrollments/Additions
(Complete A, E, F, N, O)
(Select Coverages G-M)

❒ _____/_____/_____ Requested Effective Date (1st of month only other than birth)

Enroll in: (Select all that apply)
❒ Medical ❒ Dental ❒ Vision ❒ Life/ADD/LTD ❒ ID Theft

Reason: (Select One)
❒ Open Enrollment/Renewal
❒ Add Dependent
- ❒ Date of Birth: ____/____/_____
- ❒ Date of Marriage: ____/____/_____
- ❒ Adoption (requires legal documentation)

❒ New Hire
❒ Status Change (Part to Full-time) ____/____/_____
❒ Re-hire
❒ Involuntary Loss of Coverage
❒ Other _____

The following documents are required and must be submitted within 30 days of an associated qualifying event:
HIPAA Certificate if enrolling due to loss of coverage; Marriage Certificate if enrolling a spouse due to a qualifying event; Birth Certificate if adding a dependent child; Declaration of Cohabitation & Financial Interdependence Form if enrolling a domestic partner due to a qualifying event. Note: Additional documentation may be required.

B. Waive Coverage
(Complete B, E, N, O)

❒ ____/____/____ Requested Date to Waive Coverage (1st of month only)

Waive coverages: (Select One)

	Covered elsewhere?	
❒ Medical	❒ Y	❒ N
❒ Dental	❒ Y	❒ N
❒ Vision	❒ Y	❒ N

C. Change Requests
(Complete C, N, O)
(List changes in E, F)

❒ ____/____/____ Requested Effective Date

Change Type: (Select One)
❒ Name Change ❒ Address Change
❒ Other: _____

D. Terminations
(Complete D, E, F[1], N, O)

Requested Termination Date (must be the last day of a month) ❒ __/__/__

Reason:
❒ No Longer Employed
❒ Cancel Coverage
❒ Other_____

❒ Medical	❒ Dental	❒ Vision	❒ Life/ADD/LTD	❒ ID Theft
❒ Employee	❒ Employee	❒ Employee	❒ Employee	❒ Employee
❒ Spouse	❒ Spouse	❒ Spouse	❒ Spouse	❒ Spouse
❒ Child(ren)[1]	❒ Child(ren)[1]	❒ Child(ren)[1]	❒ Child(ren)[1]	❒ Child(ren)[1]

Indicate the coverages and members to terminate above. [1] *If terminating coverage for one or more child(ren)on the policy (but not all), list in Section F the child(ren) who should have their coverage terminated. If no child(ren) are separately listed in Section F, all dependent children on the policy will be terminated.*

E. Employee Information

Group Name | Hire Date* (MM/DD/YYYY)

Prefix | First Name* | Middle Initial | Last Name* | Suffix | Social Security #*

Date of Birth* (MM/DD/YYYY) _____/_____/_____ | Gender*: ❒ Male ❒ Female | Marital Status: ❒ Divorced ❒ Domestic Partner ❒ Legally Separated ❒ Married ❒ Single ❒ Widowed

Address* | Apt | City/State/Zip* | County

Home Phone | Cell Phone | Home Email

Work Phone/Ext | Work Email | Preferred Email: ❒ Home ❒ Work

F. Dependent Demographics

Dependent 1
Prefix | First Name* | Middle Initial | Last Name* | Date of Birth* (MM/DD/YYYY) _____/_____/_____ | Social Security #*

Gender*: ❒ Male ❒ Female
Disabled? (Requires Additional Documents) ❒ Yes ❒ No
Marital Status: ❒ Divorced ❒ Domestic Partner ❒ Legally Separated ❒ Married ❒ Single ❒ Widowed

Relationship*: ❒ Spouse ❒ Domestic Partner ❒ Child ❒ Domestic Partner Child

Dependent 2
Prefix | First Name* | Middle Initial | Last Name* | Date of Birth* (MM/DD/YYYY) _____/_____/_____ | Social Security #*

Gender*: ❒ Male ❒ Female
Disabled? (Requires Additional Documents) ❒ Yes ❒ No
Marital Status: ❒ Divorced ❒ Domestic Partner ❒ Legally Separated ❒ Married ❒ Single ❒ Widowed

Relationship*: ❒ Spouse ❒ Domestic Partner ❒ Child ❒ Domestic Partner Child

Dependent 3
Prefix | First Name* | Middle Initial | Last Name* | Date of Birth* (MM/DD/YYYY) _____/_____/_____ | Social Security #*

Gender*: ❒ Male ❒ Female
Disabled? (Requires Additional Documents) ❒ Yes ❒ No
Marital Status: ❒ Divorced ❒ Domestic Partner ❒ Legally Separated ❒ Married ❒ Single ❒ Widowed

Relationship*: ❒ Spouse ❒ Domestic Partner ❒ Child ❒ Domestic Partner Child

Employee Name:_____ Group Name/ Group #:_____

G. Medical

Coverage for (Select one): ❒Employee Only ❒Employee/Spouse ❒Employee/Child(ren) ❒Family

	CareConnect To enroll with CareConnect employees must live or work in the following counties; Nassau, Suffolk, Manhattan, Brooklyn, Queens, Bronx, Richmond and Westchester	OXFORD HEALTH PLANS **Gated medical plan – Requires the selection of a PCP (complete Section H). Require referrals to see specialists.
Platinum	❑CareConnect Standard Platinum EPO ❑CareConnect Value Platinum EPO	❑Oxford Freedom Platinum EPO 5/15
Gold	❑CareConnect Tradition Gold Copay EPO ❑CareConnect Value Gold Copay EPO	❑Oxford Freedom Gold EPO 15/30 ❑Oxford Liberty Gold EPO 30/60** ❑Oxford Metro Gold EPO 25/40 NG ❑Oxford Metro Gold EPO 25/40**
Silver	❑CareConnect Tradition Silver EPO 40/60 HRx ❑CareConnect Tradition Silver EPO HSA 100% ❑CareConnect Value Silver EPO	❑Oxford Freedom Silver PPO 40/70 ❑Oxford Liberty Silver EPO 40/70 ❑Oxford Liberty Silver EPO HSA 80% ❑Oxford Metro Silver EPO 30/60**
Bronze	❑CareConnect Standard Bronze EPO ❑CareConnect Tradition Bronze EPO HSA 100%	❑Oxford Metro Bronze EPO HSA 100%**

H. PCP Selection**

Employee _____ Dependent 1 _____ Dependent 2 _____ Dependent 3 _____

If enrolling in a gated medical plan** for the first time, you must select a primary care physician (PCP) for each member by listing the Provider ID # above. If you do not select a PCP at initial enrollment one will be assigned. To change PCPs after initial enrollment you must contact the carrier directly.

I. Dental

Coverage for (Select one): ❒Employee Only ❒Employee/Spouse ❒Employee/Child(ren) ❒Family

GUARDIAN DentalGuard	❑Guardian Managed DentalGuard (DMO)*** ❑Guardian DentalGuard Preferred (PPO)	GUARDIAN DentalGuard *Plus*	❑Guardian Managed DentalGuard *Plus* (DMO)*** ❑Guardian DentalGuard Preferred *Plus* (PPO)
Solstice EPO	❑Solstice Dental EPO	Solstice PPO	❑Solstice Dental PPO

J. Dental Facility***

Employee _____ Dependent 1 _____ Dependent 2 _____ Dependent 3 _____

If enrolling in a DMO plan*** for the first time, you must select a Dental Facility ID # for each member by listing the Dental Facility # above. If you do not select a facility at initial enrollment one will be assigned. To change the facility after initial enrollment you must contact the carrier directly.

K. Vision

Coverage for (Select one): ❒Employee Only ❒Employee/Spouse ❒Employee/Child(ren) ❒Family

GUARDIAN VisionGuard	❒ I choose to elect Guardian VisionGuard
Solstice Vision	❒ I choose to elect Solstice Vision PPO

L. Life/ADD/LTD

Coverage type (Select one): GUARDIAN ❒ EverGuard ❒ EverGuard *Plus*

Indicate the percent of life insurance proceeds for each beneficiary below (must total 100%).

Beneficiary Name 1*	Relation*	Percent*	Beneficiary Name 2*	Relation*	Percent*

M. ID Theft

PrivacyArmor

Coverage for (Select one): ❒ Employee Only ❒ Family

Coverage type (Select one): ❒ PrivacyArmor ❒ PrivacyArmor Plus

LifeLock

Coverage for (Select one): ❑ Employee Only ❑ Employee/Spouse ❑ Employee/Child(ren) ❑ Family

Coverage type (Select one): ❒ Benefit Elite ❑ Ultimate Plus™

A phone number is required when enrolling in either plan and a valid email address is required for LifeLock Ultimate Plus™ enrollment. Please include your preferred email in Section E. By submitting your enrollment in LifeLock service, you represent that you have the authority to enroll those dependents indicated in LifeLock service and you have read and agreed to LifeLock's Terms and Conditions which can be found at https://www.lifelock.com/legal/terms on behalf of yourself and on behalf of any member of your family you are enrolling.

N. Employee Signature

I hereby apply for the health insurance company and benefit plans 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 benefit 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 and your dependents, 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 adoptions, you may be able to enroll yourself and your dependents, provided that your request enrolment 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 materiel 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: X_____ Date: X_____

O. Authorized Signature

I certify that the person(s) presented on this form are eligible employees or dependents and work for the employer identified on this form. This form and all other enrollment documentation submitted on by the employer, or its duly authorized officer, must be fully complete and turned in by the 20th of the month prior for effective coverage for the 1st of the following month. Any documentation received after the 20th of the month will be subject to a mirrored processing period of 10-13 active business days.

Authorized Signature: X_____ Date: X_____ HealthPass Group #: _____