



2019 ENROLLMENT/CHANGE FORM

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Employee Name:

Group Name/Group #:

A. Enrollments/Additions - Complete A, E, F, O, P and select coverages G - N

Requested Effective Date (1st of the month only other than birth)

____/____/____

Enroll in (select all that apply):

- Medical Vision Accident
- Dental Life/ADD/LTD ID Theft

Reason (Select one):

- Open Enrollment/Renewal New Hire Involuntary Loss of Coverage
- Add Dependent Rehire Other _____
- Date of Birth _____/_____/_____ Status Change (part-time to full-time) _____/_____/_____
- Date of Marriage _____/_____/_____ Adoption (requires legal documentation)

The following documents are required and must be submitted within 30 days of an associated qualifying event: HIPAA Certificate or Carrier Termination Letter if enrolling due to loss of coverage; Marriage Certificate if enrolling a spouse due to a qualifying event; Birth Certificate if adding a newborn to the policy outside 30 days of the qualifying event (DOB); 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, O, P

Requested Effective Date (1st of the month only)

____/____/____

Waive coverages (Select one):

- Medical
- Dental
- Vision

Covered elsewhere?

- Y N
- Y N
- Y N

C. Change Requests - Complete C, O, P and list changes in E, F

Requested Effective Date:

____/____/____

Change Type (Select one):

- Name Change Address Change Other _____

D. Terminations - Complete D, E, F1, O, P. Termination date must be the last day of the month.

Requested Effective Date

____/____/____

Reason:

- No longer Employed Cancel Coverage Other _____

- | | | | | | |
|--------------------------------------|--------------------------------------|--------------------------------------|---------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Medical | <input type="checkbox"/> Dental | <input type="checkbox"/> Vision | <input type="checkbox"/> Life/ADD/LTD | <input type="checkbox"/> Accident | <input type="checkbox"/> ID Theft |
| <input type="checkbox"/> Employee | <input type="checkbox"/> Employee | <input type="checkbox"/> Employee | <input type="checkbox"/> Employee | <input type="checkbox"/> Employee | <input type="checkbox"/> Employee |
| <input type="checkbox"/> Spouse | <input type="checkbox"/> Spouse | <input type="checkbox"/> Spouse | <input type="checkbox"/> Spouse | <input type="checkbox"/> Spouse | <input type="checkbox"/> Spouse |
| <input type="checkbox"/> Child(ren)1 | <input type="checkbox"/> Child(ren)1 | <input type="checkbox"/> Child(ren)1 | <input type="checkbox"/> Child(ren)1 | <input type="checkbox"/> Child(ren)1 | <input type="checkbox"/> Child(ren)1 |

Indicate the coverage(s) and member(s) 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*: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Single <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Married <input type="checkbox"/> Widowed		
Address*		Apt	City/State/Zip*		County
Home Phone/Cell Phone*			Work Phone		
Email*					

F. Dependent Demographics

Dependent 1

Prefix	First Name*	Middle Initial	Last Name*	Date of Birth* (MM/DD/YYYY) ____/____/____	Social Security #*
Gender*: <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled? (Requires Additional Documents) <input type="checkbox"/> Yes <input type="checkbox"/> No		Marital Status: <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Single <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Married <input type="checkbox"/> Widowed		
Relationship*:	<input type="checkbox"/> Spouse	<input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Child	<input type="checkbox"/> Domestic Partner Child	

Dependent 2

Prefix	First Name*	Middle Initial	Last Name*	Date of Birth* (MM/DD/YYYY) ____/____/____	Social Security #*
Gender*: <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled? (Requires Additional Documents) <input type="checkbox"/> Yes <input type="checkbox"/> No		Marital Status: <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Single <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Married <input type="checkbox"/> Widowed		
Relationship*:	<input type="checkbox"/> Spouse	<input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Child	<input type="checkbox"/> Domestic Partner Child	

Dependent 3

Prefix	First Name*	Middle Initial	Last Name*	Date of Birth* (MM/DD/YYYY) ____/____/____	Social Security #*
Gender*: <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled? (Requires Additional Documents) <input type="checkbox"/> Yes <input type="checkbox"/> No		Marital Status: <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Single <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Married <input type="checkbox"/> Widowed		
Relationship*:	<input type="checkbox"/> Spouse	<input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Child	<input type="checkbox"/> Domestic Partner Child	

Employee Name:

Group Name/Group #:

G. Medical (Select one): Employee Only Employee/Spouse Employee/Child(ren) Family



To enroll, employees must live or work in the five boroughs and Nassau or Suffolk.



To enroll, employees must live/work/reside in the following NY counties: five boroughs, Nassau, Suffolk, Westchester and Rockland.



To enroll in Liberty NG (non-gated) plans, employees can live anywhere in the US. To enroll in Liberty Advantage & Liberty G (gated) plan, employees must live in NY, NJ or CT. Members have access to Choice Plus when they travel or have children attending college outside of the Oxford service area (NY/NJ/CT). To enroll in Metro plans, employees must live or work in NY or NJ.

Platinum Plans

Healthfirst Platinum Pro EPO

Oscar Circle Platinum

Oscar Circle Plus Platinum

Oxford Liberty Advantage Platinum EPO 15/35 G

Gold Plans

Healthfirst Gold Pro EPO
Healthfirst Gold 25/50/0 Pro EPO

Oscar Circle Gold
Oscar Circle Gold 750
Oscar Circle Gold 2000

Oscar Circle Plus Gold
Oscar Circle Plus Gold 750
Oscar Circle Plus Gold 2000

Oxford Liberty Gold EPO 30/60 NG
Oxford Liberty Gold EPO 30/60 G
Oxford Metro Gold EPO 25/40 NG
Oxford Metro Gold EPO 25/40 G

Silver Plans

Healthfirst Silver Pro EPO
Healthfirst Silver 40/75/4700 Pro EPO

Oscar Circle Silver
Oscar Circle Silver 2700
Oscar Circle Silver 4500
Oscar Circle Silver HSA 3000

Oscar Circle Plus Silver
Oscar Circle Plus Silver 2700
Oscar Circle Plus Silver 4500
Oscar Circle Plus Silver HSA 3000

Oxford Liberty Silver EPO 40/70 NG
Oxford Liberty Advantage Silver EPO 30/70 G
Oxford Metro Silver EPO 30/80 NG
Oxford Metro Silver EPO 30/80 G

Bronze Plans

Healthfirst Bronze Pro EPO HSA
Healthfirst Bronze 6650 Pro EPO HSA

Oscar Circle Bronze 4000
Oscar Circle Bronze 7900
Oscar Circle Bronze HSA 6650

Oscar Circle Plus Bronze 4000
Oscar Circle Plus Bronze 7900
Oscar Circle Plus Bronze HSA 6650

Oxford Liberty Bronze EPO HSA 3300 NG
Oxford Metro Bronze EPO HSA 6550 G

H. PCP Selection

Employee# _____

Dependent 2# _____

Dependent 1# _____

Dependent 3# _____

If enrolling in Healthfirst or an Oxford G (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.

Employee Name:

Group Name/Group #:

I. Dental (Select one plan)

Coverage for (Select one):	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee/Spouse	<input type="checkbox"/> Employee/Child(ren)	<input type="checkbox"/> Family
Guardian	<input type="checkbox"/> Managed DentalGuard DHMO**	<input type="checkbox"/> Managed DentalGuard <i>Plus</i> DHMO**		
	<input type="checkbox"/> DentalGuard Preferred PPO MAC	<input type="checkbox"/> DentalGuard Preferred PPO <i>Plus</i> MAC		
Solstice	<input type="checkbox"/> Dental EPO S700B	<input type="checkbox"/> Dental EPO S800B		
	<input type="checkbox"/> Dental PPO	<input type="checkbox"/> Dental Value PPO MAC		
UnitedHealthcare	<input type="checkbox"/> Select Managed Care	<input type="checkbox"/> INO 100/50/50		
	<input type="checkbox"/> Low PPO MAC	<input type="checkbox"/> High PPO MAC		

J. Dental Facility**

Employee# _____ Dependent 2# _____
 Dependent 1# _____ Dependent 3# _____

If enrolling in a DHMO 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):	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee/Spouse	<input type="checkbox"/> Employee/Child(ren)	<input type="checkbox"/> Family
Coverage type (Select one):	<input type="checkbox"/> Guardian VisionGuard	<input type="checkbox"/> Solstice Vision PPO	<input type="checkbox"/> UnitedHealthcare Vision PPO	

L. Life/ADD/LTD

Coverage type (Select one): 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. Accident

Coverage type (Select one):	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee/Spouse	<input type="checkbox"/> Employee/Child(ren)	<input type="checkbox"/> Family
<input type="checkbox"/> Guardian AccidentGuard Adv	To enroll in the Guardian Accident Plan: comprehensive hospital, surgical and medical insurance is required on the effective date of this application for all enrollees.			

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

N. ID Theft

InfoArmor	Coverage for (Select one):	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Family	
	Coverage type (Select one):	<input type="checkbox"/> PrivacyArmor	<input type="checkbox"/> PrivacyArmor Plus	
LifeLock	Coverage for (Select one):	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee/Spouse	<input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Family
	Coverage type (Select one):	<input type="checkbox"/> Benefit Elite	<input type="checkbox"/> Ultimate Plus™	

A phone number is required when enrolling in either plan. 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.

Employee Name:

Group Name/Group #:

O. 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 any 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 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. I understand that if I am declining enrollment for myself or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself and my dependents, provided that I request enrollment within 30 days after the other applicable coverage ends. (See HealthPass' Eligibility Guidelines). In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoptions, I may be able to enroll myself and my dependents, provided that I 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 to me and remit the same to HealthPass. I understand that the subscriber is responsible for the total cost of care received and/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: X _____ Date: X _____

P. Authorized Signature

I certify that the person(s) presented on this form are eligible employees or dependents and the employee works for the employer identified on this form. This form and all other enrollment documentation submitted by the employer, or its duly authorized officer, must be fully complete and transacted 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 result in delays in enrollment up to 10-12 business days.

Authorized Signature: X _____ Date: X _____

Q. More Products & Services

For more valued HealthPass Products & Services, such as pet insurance and a hearing benefit program, visit <http://www.healthpass.com/more-products-and-services.html> to find out more and enroll.