2020 ENROLLMENT/CHANGE FORM

www.healthpassny.com ● P 888-313-7277 ● forms@healthpassny.com

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/AD&D/LTD ❒ID Theft

Reason (Select one):

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

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):

Covered elsewhere?

❒Medical ❒Y ❒N
❒Dental ❒Y ❒N
❒Vision ❒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_____

❒**Medical**	❒**Dental**	❒**Vision**	❒**Life/AD&D/LTD**	❒**Accident**	❒**ID Theft**
❒Employee	❒Employee	❒Employee	❒Employee	❒Employee	❒Employee
❒Spouse	❒Spouse	❒Spouse	❒Spouse	❒Spouse	❒Spouse
❒Child(ren)	❒Child(ren)	❒Child(ren)	❒Child(ren)	❒Child(ren)	❒Child(ren)

Indicate the coverage(s) and member(s) to terminate above. Select Child(ren) - If terminating coverage for one or more child(ren) on the policy (but not all) then list in Section F those who should have their coverage terminated. **NOTE** - 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 ❒Legally Separated ❒Single ❒Domestic Partner ❒Married ❒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*: ❒ Male ❒Female

Disabled? (Requires Additional Documents) ❒Yes ❒No

Marital Status: ❒Divorced ❒Legally Separated ❒Single ❒Domestic Partner ❒Married ❒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 ❒Legally Separated ❒Single ❒Domestic Partner ❒Married ❒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 ❒Legally Separated ❒Single ❒Domestic Partner ❒Married ❒Widowed

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

Employee Name: **Group Name/Group #:**

G. Medical (Select one): ❒Employee Only	❒Employee/Spouse	❒Employee/Child(ren)	❒Family
EmblemHealth To enroll in Prime plans employees must live/work/reside in NY, NJ and CT. To enroll in Select Care plans employees must live/work/reside in NY. To enroll in Millennium plans employees must live/work/reside in the five boroughs, Nassau, Suffolk and Westchester.			
❒Prime Platinum POS ❒Prime Platinum Premier ❒Select Care Platinum Premier	❒Prime Gold POS ❒Prime Gold Premier ❒Select Care Gold Premier	❒Prime Silver Premier ❒Select Care Silver Premier ❒Select Care Silver Value ❒Millennium Silver Value G ❒Prime Silver HSA	❒Prime Bronze HSA ❒Select Care Bronze Premier ❒Select Care Bronze Value ❒Millennium Bronze Premier G ❒Millennium Bronze Value G
healthfirst Health Insurance for New Yorkers To enroll in Pro plans employees must live/work/reside in the five boroughs, Nassau and Suffolk.			
❒Platinum Pro EPO	❒Gold Pro EPO ❒Gold 25/50/0 Pro EPO	❒Silver Pro EPO ❒Silver 40/75/4700 Pro EPO	❒Bronze Pro EPO HSA ❒Bronze 6650 Pro EPO HSA ❒Bronze 8150 Pro EPO
oscar To enroll in Circle plans employees must live/work/reside in the five boroughs, Nassau, Suffolk, Westchester and Rockland. To enroll in Circle Plus plans no more than 20% of eligible employees can live outside of the five boroughs, Nassau, Suffolk, Westchester, Rockland and the Oscar NJ service area. **Please note that by electing Oscar coverage through HealthPass any existing primary coverage through Oscar directly will be terminated.**			
❒Circle Platinum 2 ❒Circle Plus Platinum 2 ❒Circle Platinum 1 ❒Circle Plus Platinum 1	❒Circle Gold ❒Circle Plus Gold ❒Circle Gold 1000 ❒Circle Plus Gold 1000 ❒Circle Gold 1250 ❒Circle Plus Gold 1250 ❒Circle Gold 2000 ❒Circle Plus Gold 2000	❒Circle Silver ❒Circle Plus Silver ❒Circle Silver 3000 ❒Circle Plus Silver 3000 ❒Circle Silver 4500 ❒Circle Plus Silver 4500 ❒Circle Silver HSA 3000 ❒Circle Plus Silver HSA 3000	❒Circle Bronze 4500 ❒Circle Plus Bronze 4500 ❒Circle Bronze 8150 ❒Circle Plus Bronze 8150 ❒Circle Bronze HSA 6750 ❒Circle Plus Bronze HSA 6750
UnitedHealthcare Oxford To enroll in Liberty non-gated plans employees must live anywhere in the continental US. To enroll in Liberty gated (G) plans employees must live in NY, NJ and CT. *These 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/work in NY and NJ.			
❒Liberty Platinum EPO 40/80 411	❒Liberty Gold EPO 25/50 ZD ❒Liberty Gold EPO 30/60 G ❒Liberty Gold EPO 30/60 ❒Metro Gold EPO 25/40 ❒Metro Gold EPO 25/40 G	❒Metro Silver EPO 50/100 ZD ❒Liberty Silver EPO 40/70 ❒Liberty Silver EPO 25/50 G ❒Metro Silver EPO 30/80 G	❒Liberty Bronze EPO HSA 4000 ❒Metro Bronze EPO HSA 6750 G

H. PCP Selection

Employee# _____ Dependent 2# _____

Dependent 1# _____ Dependent 3# _____

If enrolling in EmblemHealth, 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): ❒Employee Only ❒Employee/Spouse ❒Employee/Child(ren) ❒Family

Guardian	❒Managed DentalGuard DHMO**	❒Managed DentalGuard DHMO *Plus***
	❒DentalGuard Preferred PPO MAC	❒DentalGuard Preferred PPO *Plus* MAC
Solstice	❒Dental EPO S700B	❒Dental EPO S800B
	❒Dental PPO	❒Dental Value PPO MAC
UnitedHealthcare	❒Select Managed Care	❒INO 100/50/50
	❒Low PPO MAC	❒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): ❒Employee Only ❒Employee/Spouse ❒Employee/Child(ren) ❒Family

Coverage type (Select one): ❒Guardian VisionGuard ❒Solstice Vision PPO ❒UnitedHealthcare Vision PPO

L. Life/AD&D/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): ❒Employee Only ❒Employee/Child(ren) ❒Family

❒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): ❒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. 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.