2019 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/ADD/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 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, O, P

❒Requested Effective Date (1st of the month only)

_____/_____/_____

Waive coverages (Select one):

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

Covered elsewhere?

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/ADD/LTD	❒Accident	❒ID Theft
❒Employee	❒Employee	❒Employee	❒Employee	❒Employee	❒Employee
❒Spouse	❒Spouse	❒Spouse	❒Spouse	❒Spouse	❒Spouse
❒Child(ren)1	❒Child(ren)1	❒Child(ren)1	❒Child(ren)1	❒Child(ren)1	❒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*:
❒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

healthfirst Health Insurance for New Yorkers	oscar		UnitedHealthcare Oxford
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 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): ❒Employee Only ❒Employee/Spouse ❒Employee/Child(ren) ❒Family

Guardian	❒Managed DentalGuard (DHMO)**	❒Managed DentalGuard *Plus* (DHMO)**
	❒DentalGuard Preferred (PPO)	❒DentalGuard Preferred *Plus* (PPO)
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/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): ❒Employee Only ❒Employee/Spouse ❒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 Essential	❒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.