



# Enrollment / Change Form

Effective date for action requested below

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

(New Groups 1st or 15th of the Month Only)

## HealthPass

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Orlando, FL 32809-5721  
Member Services: (888) 313-7277  
Billing: (888) 313-7010  
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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

- Cancellations
  - 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! Please remit COBRA payment with application directly to HealthPass.**

- Employee Election
- Dependent(s) Election
- Start date \_\_\_\_ / \_\_\_\_ / \_\_\_\_
- Stop date \_\_\_\_ / \_\_\_\_ / \_\_\_\_
- Qualifying Event & Date**
- Termination/Loss of Eligibility \_\_\_\_\_
- Death of Covered Employee \_\_\_\_\_
- Dependent Child Limiting Age \_\_\_\_\_
- Other \_\_\_\_\_

## **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 for waiving coverage:  Covered by other plan  Not Interested

**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 Phone ( ) ( ) Business Phone ( ) ( ) Birth Date (MM/DD/YY) \_\_\_\_ / \_\_\_\_ / \_\_\_\_  Single  Married  Divorced

### If you are selecting a plan from HIP or Health Net, 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#: \_\_\_\_\_ **\*\*If over age 19, are you a full-time student?**  Yes  No

**Dep # 2** (Last, First, Middle Initial) \_\_\_\_\_  M  F Birth Date (MM/DD/YY) \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security # \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Dr. Name: \_\_\_\_\_ ID#: \_\_\_\_\_ **\*\*If over age 19, are you a full-time student?**  Yes  No

**Dep # 3** (Last, First, Middle Initial) \_\_\_\_\_  M  F Birth Date (MM/DD/YY) \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security # \_\_\_\_ / \_\_\_\_ / \_\_\_\_





Dr. Name: \_\_\_\_\_ ID#: \_\_\_\_\_ **\*\*If over age 19, are you a full-time student?**  Yes  No

\*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.

\*\*Students must submit verification of full-time status.

**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	In & Out-of-Network	Cost-Sharing	HSA Plans
	<input type="checkbox"/> EH EPO+20-0 <input type="checkbox"/> EH EPO+30-0 <input type="checkbox"/> EH EPO+30-500 <input type="checkbox"/> EH EPO+40-500 <input type="checkbox"/> EH EPO+40-1000 <input type="checkbox"/> EH CompreHealth HMO 30/50-500 <input type="checkbox"/> EH CompreHealth HMO 20/25-200	<input type="checkbox"/> EH PPO+40-500-2000	<input type="checkbox"/> EH EPOcs+30-500 <input type="checkbox"/> EH EPOcs+40-1000 <input type="checkbox"/> EH EPOcs+40-2000	<input type="checkbox"/> EH HSA EPO 3000 <input type="checkbox"/> EH HSA EPO 5800 <input type="checkbox"/> EH HSA PPO 2500/2500
	<input type="checkbox"/> HP GHI Std 15 <input type="checkbox"/> HP GHI Std 20	<input type="checkbox"/> HP GHI Flex 15 <input type="checkbox"/> HP GHI PPO 30-0-1000	Not Available	Not Available
	<input type="checkbox"/> HP HNet Std 15 <input type="checkbox"/> HP HNet Std 20 <input type="checkbox"/> HNet EPO 25/40-0 <input type="checkbox"/> HNet EPO 30/45-300 (1500 max) <input type="checkbox"/> HNet EPO 30/50-500	<input type="checkbox"/> HP HNet Flex 15 <input type="checkbox"/> HNet POS 25/40-250-1000 <input type="checkbox"/> HNet POS 25/50-300 (1500 max)-1500	<input type="checkbox"/> HNet EPOcs 25-2000	<input type="checkbox"/> HNet HSA POS 4500
	<input type="checkbox"/> HP HIP Std 15 <input type="checkbox"/> HP HIP Std 20	Not Available	<input type="checkbox"/> HP HIP EPOcs 25-1000 <input type="checkbox"/> HP HIP EPOcs 30/50-1500	Not Available

**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)