



Medical Enrollment / Change Form

Employer Name: _____

Employee: Please Complete Sections 1 through 6

Section 1: Employee Information

Social Security Number: - -	Last Name:	First Name:	Middle Initial:
Date of Birth (MM/DD/YY): / /	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Other	
Home Street Address:	City:	State:	Zip:
Mailing Address (if different):			
Reason for change: <input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Employee <input type="checkbox"/> Other :		Date of Change : / / (M/D/YY)	Home Phone: () -

Section 2: Medical Plan (check only one box under Enroll)

Enroll	Carrier	Plan
<input type="checkbox"/>	Kaiser	HMO
<input type="checkbox"/>	Health Net	PPO Plan
<input type="checkbox"/>	WAIVE	No Coverage – Check one reason: <input type="checkbox"/> Spouse Coverage (or) <input type="checkbox"/> Other - Describe:

Section 3: Medical Plan Benefit Election (check only one box)

Employee Employee + Spouse Employee + Child(ren) Employee + Family

Section 4: Enrollment Information (Use a second enrollment form if you have more than 3 children)

Medical	Last Name, First Name, Middle Initial	Gender (M/F)	Date of Birth (M/D/YY)	Social Security Number *	Existing Patient?	Your Legal Dependent?	Disabled?
<input type="checkbox"/> Add <input type="checkbox"/> Remove	Employee:				<input type="checkbox"/> Yes <input type="checkbox"/> No	N/A	N/A
<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Spouse <input type="checkbox"/> Registered Domestic Partner <input type="checkbox"/> Non-Registered Domestic Partner		/ /	- -	<input type="checkbox"/> Yes <input type="checkbox"/> No	N/A	N/A
<input type="checkbox"/> Add <input type="checkbox"/> Remove	Child:		/ /	- -	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add <input type="checkbox"/> Remove	Child:		/ /	- -	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add <input type="checkbox"/> Remove	Child:		/ /	- -	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section 5: Other Insurance

Are you, your spouse or dependent(s) covered by Medicare or any other Health Insurance? Yes No **If yes, please complete the following:**

Employer sponsoring other plan: _____ Other plan's insurance company: _____

Name(s) of Individual(s) from Section 4 above who are covered by other insurance: _____ If Medicare indicate:
 Part A Part B Effective date _____ Medicare ID # _____

Did you and/or any of your Dependents have health insurance prior to enrolling? No Yes, attach your Certificate of Creditable Coverage from your current or prior health plan. You may be eligible for prior coverage credit towards pre-existing or other coverage limitations.

Section 6: Employee Acknowledgment of Binding Effect of Benefit Elections and Payroll Deductions & Disclosure of Confidential Information.

EMPLOYEE ACKNOWLEDGMENT OF BINDING EFFECT OF BENEFIT ELECTIONS AND PAYROLL DEDUCTIONS

I understand that:

- By signing and submitting this form, I am making a legally binding election of my benefits and authorizing corresponding payroll deductions (if applicable);
- I cannot change my elections during the plan year unless I have a status change event or change in cost or coverage;
- The coverage provided will be subject to the terms and conditions of the group insurance policy;
- I certify that, in the "Other Insurance" (Section 5) above, I have disclosed any other group health coverage for me or an eligible dependent.
- I certify that the information above is true and correct to the best of my knowledge and I understand that my benefits may be affected by failure to provide complete, accurate and timely information. I understand that 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 act, which is a crime and subjects such person to criminal and civil penalties.
- I have read and agree to the Authorization to Disclose Confidential Information below.

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

I understand that after I enroll, the Carrier selected in Section 2 above (Carrier) may need to obtain Confidential Information. I also understand that the Carrier may need to provide this Confidential Information to others. "Confidential Information" means, with respect to me and any covered dependents, and medical, dental, mental health, substance abuse, communicable disease, AIDS, or HIV related information and disability or employment related information. Any person or entity having Confidential Information has my permission to provide this Confidential Information upon request to: (a) Carrier, (b) any Carrier participating provider, or (c) any other provider or entity performing a service, for the purpose of plan administration, the performance of any Carrier program or operations, or to assess the quality of and access to healthcare services and supplies; Carrier has my permission to give any Confidential Information to any person, company or entity when it determines that such disclosure is necessary or appropriate for: (a) the administration of the plan, (b) the performance of Carrier programs and operations, (c) assessing quality and accessibility of healthcare services and supplies, or (d) reporting to third parties involved in plan administration; I am making this authorization for myself and as the agent or representative of my spouse and any dependent children. I understand that it will remain in effect until I send a written notice revoking it to the Carrier or for such shorter period as required by law. Until revoked, this authorization may be relied upon by the Carrier and other parties.

Employee Signature _____ **Date:** _____

EMPLOYER SECTION – TO BE COMPLETED BY THE EMPLOYER

Date of Hire : (MM/DD/YY) / /	Date of Termination : (MM/DD/YY) / /	Employment Status: <input type="checkbox"/> Active <input type="checkbox"/> COBRA	Employee Type: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time
<input type="checkbox"/> Benefit Effective or <input type="checkbox"/> Termination Date (check one) : (MM/DD/YY) / /		Authorized Representative Name:	
Authorized Representative Signature:			Date:

This plan imposes a preexisting condition exclusion. This means that if you have a medical condition before coming on our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within a 6-month period. Generally, this 6-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 6-month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 31 days after birth, adoption, or placement for adoption. You can reduce the length of this exclusion period by the number of days of your prior "Creditable Coverage".

Definition: "Creditable Coverage" means health care coverage under a group or individual Health Benefit Plan, Medicare, Medicaid, military-sponsored health care, a medical care program of the Indian Health Service or of a tribal organization, a state health benefits risk pool, a Federal Employees' Health Benefit Plan (FEHBP), a public health plan, or a Health Benefit Plan under the Peace Corps Act, except coverage consisting solely of coverage of benefits for which credit is not required under applicable law. Coverage is Creditable only if there had not been a gap in coverage exceeding 63 days.

If you are declining enrollment for yourself or your Dependents (including your spouse or Registered Domestic Partner) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in this plan if you or your Dependents lose eligibility for that other coverage (or if your employer stops contributing toward your or your Dependents' other coverage). However you must request enrollment within 31 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage). 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. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. If you previously declined enrollment in this plan for yourself or your Dependents because of coverage under a Medicaid plan or CHIP plan, you can enroll within 60 days of loss of such coverage. If you become eligible for premium assistance under a Medicaid plan or CHIP plan, you or your Dependents can enroll in this plan within 60 days of becoming eligible for premium assistance.