www.healthpassny.com

Enrollment/Change Form

New & Existing Groups

P 888.313.7277 F 888.354.7277 forms@healthpassny.com

A. Enrollments/Additions

(Complete A, E, F, N, O)
(Select Coverages G-M)

❒ _____/_____/_______ Requested Effective Date (1st of month only other than birth)

Enroll in: (Select all that apply)
❒ Medical ❒ Dental ❒ Vision ❒ Life/ADD/LTD ❒ ID Theft

Reason: (Select One)
❒ Open Enrollment/Renewal
❒ Add Dependent
  ❒ Date of Birth: ____/____/_____
  ❒ Date of Marriage: ____/____/_____
  ❒ Adoption (requires legal documentation)
❒ New Hire
❒ Status Change (Part to Full-time) ____/____/_____
❒ Re-hire
❒ Involuntary Loss of Coverage
❒ Other ________________________________

The following documents are required and must be submitted within 30 days of an associated qualifying event:
HIPAA Certificate 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, N, O)

❒ ____/____/_____ Requested Date to Waive Coverage (1st of month only)

Waive coverages: (Select One)

	Covered elsewhere?
❒ Medical	❒ Y ❒ N
❒ Dental	❒ Y ❒ N
❒ Vision	❒ Y ❒ N

C. Change Requests

(Complete C, N, O)
(List changes in E, F)

❒ ____/____/_____ Requested Effective Date

Change Type: (Select One)
❒ Name Change ❒ Address Change
❒ Other: ______________________________

D. Terminations

(Complete D, E, F[1], N, O)

Requested Termination Date (must be the last day of a month) ❒ __/__/__

Reason:
❒ No Longer Employed
❒ Cancel Coverage
❒ Other____________

❒ Medical	❒ Dental	❒ Vision	❒ Life/ADD/LTD	❒ ID Theft
❒ Employee	❒ Employee	❒ Employee	❒ Employee	❒ Employee
❒ Spouse	❒ Spouse	❒ Spouse	❒ Spouse	❒ Spouse
❒ Child(ren)[1]	❒ Child(ren)[1]	❒ Child(ren)[1]	❒ Child(ren)[1]	❒ Child(ren)[1]

Indicate the coverages and members 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 ❒ Domestic Partner ❒ Legally Separated ❒ Married ❒ Single ❒ Widowed

Address* | Apt | City/State/Zip* | County

Home Phone | Cell Phone | Home Email

Work Phone/Ext | Work Email

Preferred Email: ❒ Home ❒ Work

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 ❒ Domestic Partner ❒ Legally Separated ❒ Married ❒ Single ❒ 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 ❒ Domestic Partner ❒ Legally Separated ❒ Married ❒ Single ❒ 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 ❒ Domestic Partner ❒ Legally Separated ❒ Married ❒ Single ❒ Widowed

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

Employee Name:_______________ Group Name/ Group #:_______________

G. Medical

Coverage for (Select one): ❑Employee Only ❑Employee/Spouse ❑Employee/Child(ren) ❑Family

	healthfirst	oscar	OXFORD HEALTH PLANS
	Employees must live or work in the five boroughs and Nassau.	Employees must live or work in the following NY counties: five boroughs, Nassau, Suffolk, Westchester and Rockland – or work in one of those NY counties and live in one of the following NJ counties: Middlesex, Union, Hudson, Essex, Morris, Passaic, Bergen, Monmouth and Ocean.	Freedom plans, employees can live anywhere in the US. Liberty plans, employees can live anywhere in the US. Although to enroll in the Liberty Gold EPO, employees must live in NY, NJ or CT. Metro plans, employees must live or work in NY or NJ.
Platinum	❑Healthfirst Platinum Pro EPO	❑Oscar Market Platinum EPO ❑Oscar Simple Platinum EPO	❑Oxford Freedom Platinum EPO 5/15
Gold	❑Healthfirst Gold Pro EPO	❑Oscar Market Gold EPO ❑Oscar Simple Gold EPO	❑Oxford Freedom Gold EPO 15/30 ❑Oxford Liberty Gold EPO 30/60** ❑Oxford Metro Gold EPO 25/40 NG ❑Oxford Metro Gold EPO 25/40**
Silver	❑Healthfirst Silver Pro EPO	❑Oscar Market Silver EPO ❑Oscar Simple Silver EPO	❑Oxford Freedom Silver PPO 40/70 ❑Oxford Liberty Silver EPO 40/70 ❑Oxford Liberty Silver EPO HSA 80% ❑Oxford Metro Silver EPO 30/60**
Bronze	❑Healthfirst Bronze Pro EPO	❑Oscar Market Bronze EPO ❑Oscar Simple Bronze EPO	❑Oxford Metro Bronze EPO HSA 100%**

PCP Selection**

Employee _______ Dependent 1 _______ Dependent 2 _______ Dependent 3 _______

If enrolling in Healtfirst or an Oxford 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.

H. Dental

Coverage for (Select one): ❑Employee Only ❑Employee/Spouse ❑Employee/Child(ren) ❑Family

GUARDIAN	**DentalGuard**	❑Managed DentalGuard (DMO)*** ❑DentalGuard Preferred (PPO)	GUARDIAN	**DentalGuard *Plus***	❑Managed DentalGuard *Plus* (DMO)*** ❑DentalGuard Preferred *Plus* (PPO)
Solstice	**Solstice EPO**	❑Dental EPO ❑Dental Value EPO	Solstice	**Solstice PPO**	❑Dental PPO ❑Dental Value PPO MAC

I. Dental Facility***

Employee _______ Dependent 1 _______ Dependent 2 _______ Dependent 3 _______

If enrolling in a DMO 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.

J. Vision

Coverage for (Select one): ❑Employee Only ❑Employee/Spouse ❑Employee/Child(ren) ❑Family

GUARDIAN	**VisionGuard**	❑I choose to elect Guardian VisionGuard
Solstice	**Vision**	❑I choose to elect Solstice Vision PPO

K. Life/ADD/LTD

Coverage type (Select one): GUARDIAN ❑ 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*

L. ID Theft

INFOARMOR	**PrivacyArmor**	Coverage for (Select one): ❑Employee Only ❑Family Coverage type (Select one): ❑PrivacyArmor ❑PrivacyArmor Plus
LifeLock	**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 and a valid email address is required for LifeLock Ultimate Plus™ enrollment. Please include your preferred email in Section E.** 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.

M. 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**_______________

N. 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** _______________ HealthPass Group #:_______________