



Enrollment/Change Form

New & Existing Groups

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www.healthpassny.com

A. Enrollments/Additions

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

___/___/___
Requested Effective Date
(1st of month only other than birth)

Enroll in:
(Select all that apply)

- Medical
- Dental
- Vision
- Life/ADD/LTD
- Accident
- 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 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 Date to Waive Coverage
(1st of month only)

Waive coverages:
(Select One)

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

C. Change Requests

(Complete C, O, P)

(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)

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

Reason:

- No Longer Employed
- Cancel Coverage
- Other _____

- | | | | | | |
|--|--|--|--|--|--|
| <input type="checkbox"/> Medical | <input type="checkbox"/> Dental | <input type="checkbox"/> Vision | <input type="checkbox"/> Life/ADD/LTD | <input type="checkbox"/> Accident | <input type="checkbox"/> ID Theft |
| <input type="checkbox"/> Employee | <input type="checkbox"/> Employee | <input type="checkbox"/> Employee | <input type="checkbox"/> Employee | <input type="checkbox"/> Employee | <input type="checkbox"/> Employee |
| <input type="checkbox"/> Spouse | <input type="checkbox"/> Spouse | <input type="checkbox"/> Spouse | <input type="checkbox"/> Spouse | <input type="checkbox"/> Spouse | <input type="checkbox"/> Spouse |
| <input type="checkbox"/> Child(ren) ¹ | <input type="checkbox"/> Child(ren) ¹ | <input type="checkbox"/> Child(ren) ¹ | <input type="checkbox"/> Child(ren) ¹ | <input type="checkbox"/> Child(ren) ¹ | <input type="checkbox"/> 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*:	Marital Status:			
___/___/___	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner		<input type="checkbox"/> Legally Separated <input type="checkbox"/> Married	<input type="checkbox"/> Single <input type="checkbox"/> Widowed
Address*	Apt	City/State/Zip*	County		
Home Phone	Cell Phone	Home Email			
Work Phone/Ext	Work Email	Preferred Email:	<input type="checkbox"/> Home <input type="checkbox"/> Work	A valid email address is required when enrolling in an Oscar medical plan, Guardian AccidentGuard Adv and LifeLock Ultimate Plus™	




F. Dependent Demographics

Dependent 1	Prefix	First Name*	Middle Initial	Last Name*	Date of Birth* (MM/DD/YYYY)	Social Security #*
					___/___/___	
Gender*:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled? (Requires Additional Documents)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Marital Status:	<input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Legally Separated <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed
Relationship*:	<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner Child				
Dependent 2	Prefix	First Name*	Middle Initial	Last Name*	Date of Birth* (MM/DD/YYYY)	Social Security #*
					___/___/___	
Gender*:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled? (Requires Additional Documents)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Marital Status:	<input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Legally Separated <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed
Relationship*:	<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner Child				
Dependent 3	Prefix	First Name*	Middle Initial	Last Name*	Date of Birth* (MM/DD/YYYY)	Social Security #*
					___/___/___	
Gender*:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled? (Requires Additional Documents)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Marital Status:	<input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Legally Separated <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed
Relationship*:	<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner Child				

Employee Name: _____

Group Name/ Group #: _____

G. Medical Coverage for (Select one): Employee Only Employee/Spouse Employee/Child(ren) Family

	 Employees must live or work in the five boroughs and Nassau.	 To enroll, employees must live/work/reside in the following NY counties: five boroughs, Nassau, Suffolk, Westchester and Rockland.	 To enroll in Liberty plans (non-gated), employees can live anywhere in the US. To enroll in Liberty Advantage & Liberty Gold plans (gated), 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).
Platinum	<input type="checkbox"/> Healthfirst Platinum Pro EPO	<input type="checkbox"/> Oscar Classic Platinum EPO 2K <input type="checkbox"/> Oscar Classic Platinum EPO 3K	<input type="checkbox"/> Oxford Liberty Advantage Platinum EPO 15/35**
Gold	<input type="checkbox"/> Healthfirst Gold Pro EPO	<input type="checkbox"/> Oscar Classic Gold EPO <input type="checkbox"/> Oscar Classic Gold EPO 1K <input type="checkbox"/> Oscar Simple Gold EPO	<input type="checkbox"/> Oxford Liberty Gold EPO 30/60** <input type="checkbox"/> Oxford Liberty Advantage Gold EPO 25/45** <input type="checkbox"/> Oxford Metro Gold EPO 25/40 NG <input type="checkbox"/> Oxford Metro Gold EPO 25/40**
Silver	<input type="checkbox"/> Healthfirst Silver Pro EPO	<input type="checkbox"/> Oscar Classic Silver EPO 3K <input type="checkbox"/> Oscar Classic Silver EPO 4.5K <input type="checkbox"/> Oscar Simple Silver EPO	<input type="checkbox"/> Oxford Liberty Advantage Silver EPO 30/70** <input type="checkbox"/> Oxford Liberty Silver EPO 40/70 <input type="checkbox"/> Oxford Liberty Prim Adv Silver EPO 2K <input type="checkbox"/> Oxford Metro Silver EPO 30/60**
Bronze	<input type="checkbox"/> Healthfirst Bronze Pro EPO HSA	<input type="checkbox"/> Oscar Classic Bronze EPO <input type="checkbox"/> Oscar Simple Bronze EPO	<input type="checkbox"/> Oxford Liberty Bronze EPO HSA 70% <input type="checkbox"/> Oxford Metro Bronze EPO HSA 100%**

H. PCP Selection** Employee _____ Dependent 1 _____ Dependent 2 _____ Dependent 3 _____
If enrolling in Healthfirst 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.

I. Dental (Select 1 plan) Coverage for (Select one): Employee Only Employee/Spouse Employee/Child(ren) Family

Guardian	<input type="checkbox"/> Managed DentalGuard (DMO)***	<input type="checkbox"/> Managed DentalGuard Plus (DMO)***	<input type="checkbox"/> DentalGuard Preferred (PPO)	<input type="checkbox"/> DentalGuard Preferred Plus (PPO)
Solstice	<input type="checkbox"/> Dental EPO	<input type="checkbox"/> Dental Value EPO	<input type="checkbox"/> Dental PPO	<input type="checkbox"/> Dental Value PPO MAC
UnitedHealthcare	<input type="checkbox"/> Select Managed Care	<input type="checkbox"/> INO 100/50/50	<input type="checkbox"/> Low PPO MAC	<input type="checkbox"/> High PPO MAC

J. 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.

K. Vision Coverage for (Select one): Employee Only Employee/Spouse Employee/Child(ren) Family

<input type="checkbox"/> Guardian VisionGuard	<input type="checkbox"/> Solstice Vision PPO	<input type="checkbox"/> UnitedHealthcare Vision PPO
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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*
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M. Accident Coverage for (Select one): Employee Only Employee/Spouse Employee/Child(ren) Family

Guardian AccidentGuard Adv 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*
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N. ID Theft

PrivacyArmor 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.

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** _____ HealthPass Group #: _____