2022 ENROLLMENT/CHANGE FORM

www.healthpassny.com | P 888-313-7277

Employee Name: **Group Name/Group #:**

A. Enrollments/Additions - Complete A, E, F, Q, R and select coverages G – P

Requested Effective Date (Other than birth or adoption, all coverage effective dates are the 1st of the month following the qualifying event):

_______/_______/_______

Enroll in (select all that apply):

❒Medical ❒Vision ❒Life/AD&D/LTD ❒ID Theft
❒Dental ❒FSA & Commuter Benefits ❒Accident ❒Pet Plan

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 newborn to the policy outside 30 days of the qualifying event (DOB); 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, Q, R

Requested Effective Date
(1st of the month only)

______/______/______

Waive coverages:
❒Medical
❒Dental
❒Vision

Reason for Waiving:

Valid Waiver:
❒Spousal Coverage
❒Medicare
❒Medicaid
❒Veteran's Administration
❒Parental Waiver

Invalid Waiver:
❒Employer Sponsored Coverage
❒Individual Coverage
❒Exchange Coverage

C. Change Requests - Complete C, Q, R and list changes in E, F

Requested Effective Date:

______/______/______

Change Type:
❒Name Change ❒Address Change ❒Other______________________

D. Terminations - Complete D, E, F, Q, R. Termination date must be the last day of the month.

Requested Effective Date:

______/______/_____

Reason:
❒No Longer Employed ❒Cancel Coverage ❒ Other______________________

❒Medical
❒Employee
❒Spouse
❒Child(ren)

❒Dental
❒Employee
❒Spouse
❒Child(ren)

❒Vision
❒Employee
❒Spouse
❒Child(ren)

❒FSA & Commuter Benefits
❒Healthcare Flexible Spending Account (FSA)
❒Dependent Care Account (DCA) FSA
❒Parking Plan
❒Transit Plan

❒Life/AD&D/LTD
❒EverGuard
❒EverGuard *Plus*

❒Accident
❒Employee
❒Spouse
❒Child(ren)

❒ID Theft
❒Employee
❒Spouse
❒Child(ren)

❒Pet Plan
❒Single Pet
❒Family Pet

Indicate the coverage(s) and member(s) to terminate above. Select Child(ren) - If terminating coverage for one or more child(ren) on the policy (but not all) then list in Section F those who should have their coverage terminated. **NOTE** - 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

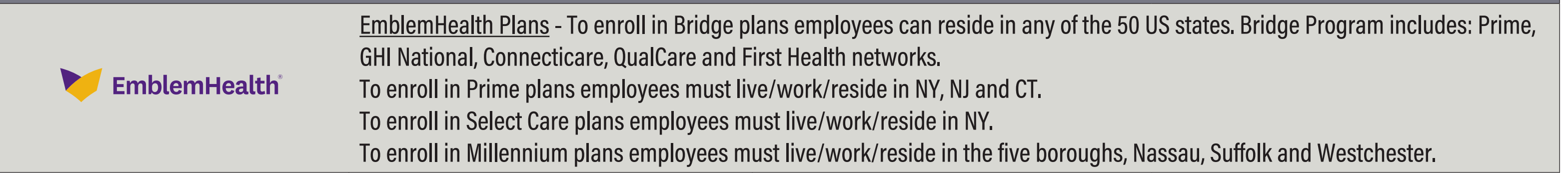
Disabled? (Requires Additional Documents) ❒Yes ❒No

Marital Status: ❒Divorced ❒Legally Separated ❒Single ❒Domestic Partner ❒Married ❒Widowed

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

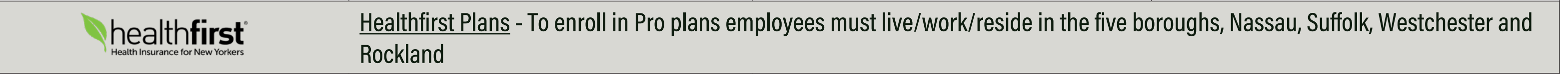
Employee Name: **Group Name/Group #:**

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



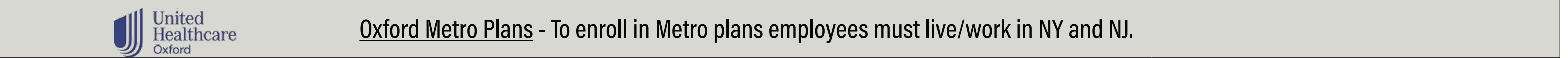
EmblemHealth Plans - To enroll in Bridge plans employees can reside in any of the 50 US states. Bridge Program includes: Prime, GHI National, Connecticare, QualCare and First Health networks.
To enroll in Prime plans employees must live/work/reside in NY, NJ and CT.
To enroll in Select Care plans employees must live/work/reside in NY.
To enroll in Millennium plans employees must live/work/reside in the five boroughs, Nassau, Suffolk and Westchester.

❒Bridge Platinum PPO ❒Prime Platinum Premier ❒Select Care Platinum Premier	❒Bridge Gold PPO ❒Prime Gold Premier ❒Prime Gold Value ❒Bridge Gold Virtual ❒Select Care Gold Premier ❒Select Care Gold Value ❒Millennium Gold Virtual	❒Prime Silver Premier ❒Select Care Silver Premier ❒Select Care Silver Value ❒Millennium Silver Value G ❒Prime Silver HSA	❒Prime Bronze HSA ❒Select Care Bronze Premier ❒Select Care Bronze Value ❒Millennium Bronze Premier G ❒Millennium Bronze Value G



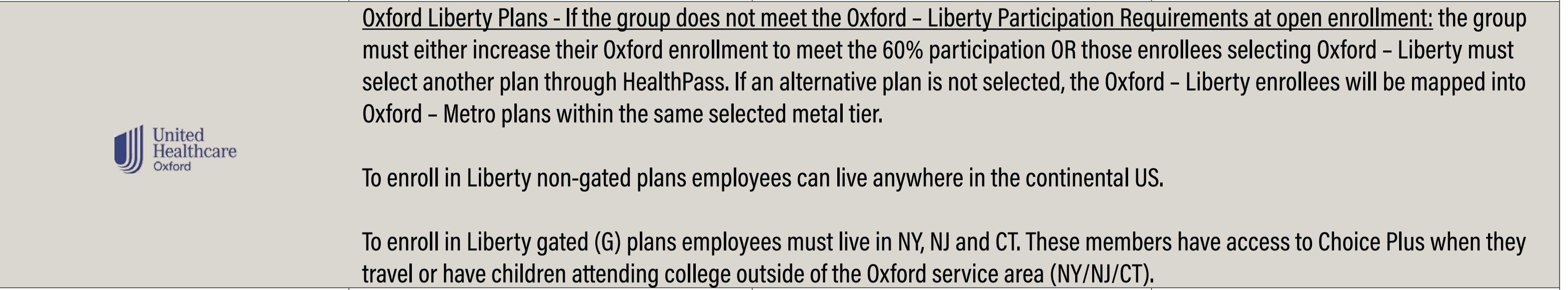
Healthfirst Plans - To enroll in Pro plans employees must live/work/reside in the five boroughs, Nassau, Suffolk, Westchester and Rockland

❒Platinum Pro EPO	❒Gold Pro EPO ❒Gold 25/50/0 Pro EPO ❒Gold 1350 Pro EPO	❒Silver Pro EPO ❒Silver 40/75/4700 Pro EPO	❒Bronze Pro EPO HSA ❒Bronze 5250 Pro EPO HSA ❒Bronze 6850 Pro EPO HSA ❒Bronze 8225 Pro EPO



Oxford Metro Plans - To enroll in Metro plans employees must live/work in NY and NJ.

N/A	❒Metro Gold EPO 25/40 G ❒Metro Gold EPO 25/40	❒Metro Silver EPO 30/80 G ❒Metro Silver EPO 50/100 ZD	❒Metro Bronze HSA 7000 G



Oxford Liberty Plans - If the group does not meet the Oxford – Liberty Participation Requirements at open enrollment: the group must either increase their Oxford enrollment to meet the 60% participation OR those enrollees selecting Oxford – Liberty must select another plan through HealthPass. If an alternative plan is not selected, the Oxford – Liberty enrollees will be mapped into Oxford – Metro plans within the same selected metal tier.

To enroll in Liberty non-gated plans employees can live anywhere in the continental US.

To enroll in Liberty gated (G) plans employees must live in NY, NJ and CT. These members have access to Choice Plus when they travel or have children attending college outside of the Oxford service area (NY/NJ/CT).

❒Liberty Platinum EPO	❒Liberty Gold EPO 30/60 ❒Liberty Gold EPO 30/60 G ❒Liberty Gold EPO 25/50 ZD ❒Liberty Gold HSA 1500 Motion	❒Liberty Silver EPO 25/50 G ❒Liberty Silver EPO 40/70 ❒Liberty Silver EPO 50/100 ZD ❒Liberty Silver HSA 4000 Motion	❒Liberty Bronze HSA 5750

G = Gated
ZD = Zero Deductible

H. PCP Selection

NOTE If enrolling in an EmblemHealth, Healthfirst or Oxford G (gated) medical plan for the first time, you must select a primary care physician (PCP) by writing the Primary Physician ID # below. **IMPORTANT:** write the exact PCP # for proper assignment. If you do not have a PCP at the moment, write 4 zeros (0000) in the field. Do NOT write a symbol/letter/space/doctor name/character or less than 4 numeric digits as those will cause enrollment issues. If you do not write a true PCP # one will be assigned to you by the carrier. To change a PCP after initial enrollment, you must contact the carrier directly.

Employee# ______________________________ Dependent 2# ______________________________

Dependent 1# ______________________________ Dependent 3# ______________________________

I. Dental (Select one plan)

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

Guardian	❒Managed DentalGuard DHMO** ❒DentalGuard Preferred PPO MAC	❒Managed DentalGuard DHMO *Plus*** ❒DentalGuard Preferred PPO *Plus* MAC
Solstice	❒Dental EPO S700B ❒Dental PPO	❒Dental EPO S800B ❒Dental Value PPO MAC
UnitedHealthcare	❒Select Managed Care ❒Low PPO MAC	❒INO 100/50/50 ❒High PPO MAC

Employee Name: **Group Name/Group #:**

J. Dental Facility**

*****NOTE***** If enrolling in a Guardian DHMO dental plan for the first time, you must select a primary care dentist (PCD) by writing the Primary Dentist ID # below. **IMPORTANT:** write the exact PCD # for proper assignment. If you do not have a PCD at the moment, write 4 zeros (0000) in the field. Do NOT write a symbol/letter/space/doctor name/character or less than 4 numeric digits as those will cause enrollment issues. If you do not write a true PCD # one will be assigned to you by the carrier. To change a PCD after initial enrollment, you must contact the carrier directly

Employee ____________________ Dependent #1____________________ Dependent #2____________________ Dependent #3____________________

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. FSA & Commuter Benefits

Select any of the plans you wish to enroll in and your amount(s):
Please note: every year you will have to re-establish your plans and amounts.

❒**Healthcare Flexible Spending Account (FSA)** **Yearly Amount: $** _________
(Confirm with your employer which plan your group offers: FSA $1000 Max, FSA $2000 Max, FSA $2850 IRS Max)

❒**Dependent Care Account (DCA) FSA** **Yearly Amount: $** _________ ($5000 IRS Max)

❒**Parking Plan** **Monthly Amount: $** _________ ($280 Max)

❒**Transit Plan** **Monthly Amount: $** _________ ($280 Max)

M. Life/AD&D/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*

N. 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*

O. ID Theft

Allstate Identity Protection
Coverage for (Select one): ❒Employee Only ❒Family
Coverage type (Select one): ❒Allstate Identity Protection Pro ❒Allstate Identity Protection Pro 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.

P. Pet Plan

Total Pet Plan Coverage type (Select one): ❒Single Pet Plan ❒Family Pet Plan (2+)

This is a discount plan bundle from Pet Benefit Solutions and includes Pet Assure, Pet Plus, AskVet and The PetTag (not insurance).

Employee Name: **Group Name/Group #:**

Q. 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________________________

R. 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________________________

S. Extra Products & Services

For more extra HealthPass Products & Services, such as pet insurance and a hearing benefit program, visit https://healthpass.com/extra-products-and-services/ to find out more and enroll.