



# 2020 ENROLLMENT/CHANGE FORM

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Employee Name:

Group Name/Group #:

## A. Enrollments/Additions - Complete A, E, F, O, P and select coverages G - N

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

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

Enroll in (select all that apply):

- Medical       Vision       Accident  
 Dental       Life/AD&D/LTD       ID Theft

Reason (Select one):

- Open Enrollment/Renewal       New Hire       Involuntary Loss of Coverage  
 Add Dependent       Rehire       Other \_\_\_\_\_  
 Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_       Status Change (part-time to full-time) \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Date of Marriage \_\_\_\_/\_\_\_\_/\_\_\_\_       Adoption (requires legal documentation)

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, O, P

Requested Effective Date (1st of the month only)

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

Waive coverages (Select one):

- Medical  
 Dental  
 Vision

Covered elsewhere?

- Y       N  
 Y       N  
 Y       N

## C. Change Requests - Complete C, O, P and 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. 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)

Life/AD&D/LTD

- Employee  
 Spouse  
 Child(ren)

Accident

- Employee  
 Spouse  
 Child(ren)

ID Theft

- Employee  
 Spouse  
 Child(ren)

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*: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Single <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Married <input type="checkbox"/> 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*: <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"/> Legally Separated <input type="checkbox"/> Single <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Married <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"/> Legally Separated <input type="checkbox"/> Single <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Married <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"/> Legally Separated <input type="checkbox"/> Single <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Married <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 #:


<b>G. Medical (Select one):</b>	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee/Spouse	<input type="checkbox"/> Employee/Child(ren)	<input type="checkbox"/> Family
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 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.


<input type="checkbox"/> Prime Platinum POS <input type="checkbox"/> Prime Platinum Premier <input type="checkbox"/> Select Care Platinum Premier	<input type="checkbox"/> Prime Gold POS <input type="checkbox"/> Prime Gold Premier <input type="checkbox"/> Select Care Gold Premier	<input type="checkbox"/> Prime Silver Premier <input type="checkbox"/> Select Care Silver Premier <input type="checkbox"/> Select Care Silver Value <input type="checkbox"/> Millennium Silver Value G <input type="checkbox"/> Prime Silver HSA	<input type="checkbox"/> Prime Bronze HSA <input type="checkbox"/> Select Care Bronze Premier <input type="checkbox"/> Select Care Bronze Value <input type="checkbox"/> Millennium Bronze Premier G <input type="checkbox"/> Millennium Bronze Value G
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 To enroll in Pro plans employees must live/work/reside in the five boroughs, Nassau and Suffolk.

<input type="checkbox"/> Platinum Pro EPO	<input type="checkbox"/> Gold Pro EPO <input type="checkbox"/> Gold 25/50/0 Pro EPO	<input type="checkbox"/> Silver Pro EPO <input type="checkbox"/> Silver 40/75/4700 Pro EPO	<input type="checkbox"/> Bronze Pro EPO HSA <input type="checkbox"/> Bronze 6650 Pro EPO HSA <input type="checkbox"/> Bronze 8150 Pro EPO
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 To enroll in Circle plans employees must live/work/reside in the five boroughs, Nassau, Suffolk, Westchester and Rockland.  
 To enroll in Circle Plus plans no more than 20% of eligible employees can live outside of the five boroughs, Nassau, Suffolk, Westchester, Rockland and the Oscar NJ service area.  
**Please note that by electing Oscar coverage through HealthPass any existing primary coverage through Oscar directly will be terminated.**

<input type="checkbox"/> Circle Platinum 2 <input type="checkbox"/> Circle Plus Platinum 2 <input type="checkbox"/> Circle Platinum 1 <input type="checkbox"/> Circle Plus Platinum 1	<input type="checkbox"/> Circle Gold <input type="checkbox"/> Circle Plus Gold <input type="checkbox"/> Circle Gold 1000 <input type="checkbox"/> Circle Plus Gold 1000 <input type="checkbox"/> Circle Gold 1250 <input type="checkbox"/> Circle Plus Gold 1250 <input type="checkbox"/> Circle Gold 2000 <input type="checkbox"/> Circle Plus Gold 2000	<input type="checkbox"/> Circle Silver <input type="checkbox"/> Circle Plus Silver <input type="checkbox"/> Circle Silver 3000 <input type="checkbox"/> Circle Plus Silver 3000 <input type="checkbox"/> Circle Silver 4500 <input type="checkbox"/> Circle Plus Silver 4500 <input type="checkbox"/> Circle Silver HSA 3000 <input type="checkbox"/> Circle Plus Silver HSA 3000	<input type="checkbox"/> Circle Bronze 4500 <input type="checkbox"/> Circle Plus Bronze 4500 <input type="checkbox"/> Circle Bronze 8150 <input type="checkbox"/> Circle Plus Bronze 8150 <input type="checkbox"/> Circle Bronze HSA 6750 <input type="checkbox"/> Circle Plus Bronze HSA 6750
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 To enroll in Liberty non-gated plans employees must 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).*  
 To enroll in Metro plans employees must live/work in NY and NJ.

<input type="checkbox"/> Liberty Platinum EPO 40/80 411	<input type="checkbox"/> Liberty Gold EPO 25/50 ZD <input type="checkbox"/> Liberty Gold EPO 30/60 G <input type="checkbox"/> Liberty Gold EPO 30/60 <input type="checkbox"/> Metro Gold EPO 25/40 <input type="checkbox"/> Metro Gold EPO 25/40 G	<input type="checkbox"/> Metro Silver EPO 50/100 ZD <input type="checkbox"/> Liberty Silver EPO 40/70 <input type="checkbox"/> Liberty Silver EPO 25/50 G <input type="checkbox"/> Metro Silver EPO 30/80 G	<input type="checkbox"/> Liberty Bronze EPO HSA 4000 <input type="checkbox"/> Metro Bronze EPO HSA 6750 G
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**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# \_\_\_\_\_

Employee Name:

Group Name/Group #:

**I. Dental (Select one plan)**

Coverage for (Select one):	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee/Spouse	<input type="checkbox"/> Employee/Child(ren)	<input type="checkbox"/> Family
<b>Guardian</b>	<input type="checkbox"/> Managed DentalGuard DHMO**	<input type="checkbox"/> Managed DentalGuard DHMO <i>Plus</i> **		
	<input type="checkbox"/> DentalGuard Preferred PPO MAC	<input type="checkbox"/> DentalGuard Preferred PPO <i>Plus</i> MAC		
<b>Solstice</b>	<input type="checkbox"/> Dental EPO S700B	<input type="checkbox"/> Dental EPO S800B		
	<input type="checkbox"/> Dental PPO	<input type="checkbox"/> Dental Value PPO MAC		
<b>UnitedHealthcare</b>	<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\*\***

\*\*\*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 2# \_\_\_\_\_  
 Dependent 1# \_\_\_\_\_ Dependent 3# \_\_\_\_\_

**K. Vision**

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

**L. 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*

**M. Accident**

Coverage type (Select one):	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee/Spouse	<input type="checkbox"/> Employee/Child(ren)	<input type="checkbox"/> Family
<input type="checkbox"/> 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*

**N. ID Theft**

<b>InfoArmor</b>	Coverage for (Select one):	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Family	
	Coverage type (Select one):	<input type="checkbox"/> PrivacyArmor	<input type="checkbox"/> PrivacyArmor Plus	
<b>NortonLifeLock</b>	Coverage for (Select one):	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee/Spouse	<input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Family
	Coverage type (Select one):	<input type="checkbox"/> Benefit Elite	<input type="checkbox"/> Ultimate Plus™	

A phone number is required when enrolling in either plan. By submitting your enrollment in NortonLifeLock service, you represent that you have the authority to enroll those dependents indicated in NortonLifeLock service and you have read and agreed to NortonLifeLock'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.

Employee Name:

Group Name/Group #:

### 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 \_\_\_\_\_

### Q. More Products & Services

For more valued HealthPass Products & Services, such as pet insurance and a hearing benefit program, visit <http://www.healthpass.com/more-products-and-services.html> to find out more and enroll.