



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 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, 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 _____

- | | | | | | | | |
|-------------------------------------|-------------------------------------|-------------------------------------|--|---|-------------------------------------|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> Medical | <input type="checkbox"/> Dental | <input type="checkbox"/> Vision | <input type="checkbox"/> FSA & Commuter Benefits | <input type="checkbox"/> Life/AD&D/LTD | <input type="checkbox"/> Accident | <input type="checkbox"/> ID Theft | <input type="checkbox"/> Pet Plan |
| <input type="checkbox"/> Employee | <input type="checkbox"/> Employee | <input type="checkbox"/> Employee | <input type="checkbox"/> Healthcare Flexible Spending Account (FSA) | <input type="checkbox"/> EverGuard | <input type="checkbox"/> Employee | <input type="checkbox"/> Employee | <input type="checkbox"/> Single Pet |
| <input type="checkbox"/> Spouse | <input type="checkbox"/> Spouse | <input type="checkbox"/> Spouse | <input type="checkbox"/> Dependent Care Account (DCA) FSA | <input type="checkbox"/> EverGuard Plus | <input type="checkbox"/> Spouse | <input type="checkbox"/> Spouse | <input type="checkbox"/> Family Pet |
| <input type="checkbox"/> Child(ren) | <input type="checkbox"/> Child(ren) | <input type="checkbox"/> Child(ren) | <input type="checkbox"/> Parking Plan
<input type="checkbox"/> Transit Plan | | <input type="checkbox"/> Child(ren) | <input type="checkbox"/> 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 #:

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

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 valued HealthPass Products & Services, such as a POP Kit Section 125 and Beyond Med, visit <https://healthpass.com/extra-products-and-services/> to find out more and enroll.