HealthPass
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Beyond Med Late Enrollment Form

Beyond Med

A. Employee Information

Requested Effective Date _____/_____/_____ (1st of the month only)

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 | Work Phone/Ext* | Email Address*

B. 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

C. Health, Wellness & Cosmetic

Beyond Med ❒ Beyond Med

Coverage for (Select one): ❒ Employee Only ❒ Family

D. 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 the 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 medical or dental 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. If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after your other coverage ends. See eligibility guidelines. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoptions, you may be able to enroll yourself and your dependents, provided that your request enrolment 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 me and remit same to HealthPass. The subscriber is responsible for the total cost of care received 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 materiel 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** _____

E. Authorized Signature

I certify that the person(s) presented on this form are eligible employees or dependents and work for the employer identified on this form. This form and all other enrollment documentation submitted on by the employer, or its duly authorized officer, must be fully complete and turned in 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 be subject to a mirrored processing period of 10-13 active business days.

Authorized Signature: **X** _____ Date: **X** _____