

Employee Name:

Group Name/Group #:

### A. Enrollments/Additions - Complete A, E, F, T, U and select coverages G -S

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

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

Reason (Select one):

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Open Enrollment/Renewal         | <input type="checkbox"/> New Hire  | <input type="checkbox"/> Involuntary Loss of Coverage |
| <input type="checkbox"/> Add Dependent                   | <input type="checkbox"/> Rehire  | <input type="checkbox"/> Other _____                  |
| <input type="checkbox"/> Date of Birth ____/____/____    | <input type="checkbox"/> Status Change (part-time to full-time) ____/____/____ |   |
| <input type="checkbox"/> Date of Marriage ____/____/____ | <input type="checkbox"/> 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, T, U

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, T, U and list changes in E, F

Requested Effective Date:

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

Change Type:

- Name Change       Address Change       Other \_\_\_\_\_

### D. Terminations - Complete D, E, F, T, U. Termination date must be the last day of the month.

Requested Effective Date:

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

Reason:

- No Longer Employed       Cancel Coverage       Other \_\_\_\_\_

<input type="checkbox"/> <b>Medical</b> <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)	<input type="checkbox"/> <b>Dental</b> <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)
<input type="checkbox"/> <b>Vision</b> <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)	<input type="checkbox"/> <b>FSA &amp; Commuter Benefits</b> <input type="checkbox"/> Healthcare Flexible Spending Account (FSA) <input type="checkbox"/> Dependent Care Account (DCA) FSA <input type="checkbox"/> Parking Plan <input type="checkbox"/> Transit Plan
<input type="checkbox"/> <b>Life/AD&amp;D</b> <input type="checkbox"/> Employer Paid Life/AD&D 50K <input type="checkbox"/> Employer Paid Life/AD&D 100K	<input type="checkbox"/> <b>Life</b> <input type="checkbox"/> Voluntary Life 25K <input type="checkbox"/> Voluntary Life 50K
<input type="checkbox"/> <b>Disability/AD&amp;D/LTD</b> <input type="checkbox"/> EverGuard <input type="checkbox"/> EverGuard Plus	<input type="checkbox"/> <b>Accident</b> <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)
<input type="checkbox"/> <b>Beyond Med</b> <input type="checkbox"/> Employee <input type="checkbox"/> Family	<input type="checkbox"/> <b>ID Theft</b> <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)
<input type="checkbox"/> <b>Pet Plan</b> <input type="checkbox"/> Single Pet <input type="checkbox"/> 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*: <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 #:

G. Medical (Select one):			
<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee/Spouse	<input type="checkbox"/> Employee/Child(ren)	<input type="checkbox"/> Family
 <p>To enroll in Connection plans employees can live/work/reside anywhere in the US.</p>			
<input type="checkbox"/> Connection Platinum EPO 20/40	<input type="checkbox"/> Connection Gold EPO 25/50 <input type="checkbox"/> Connection Gold 50/55	<input type="checkbox"/> Connection Silver EPO 40/80	N/A
 <p>If the group does not meet the PPO/EPO and Blue Access Requirements at open enrollment: employees who selected PPO/EPO and Blue Access plans will need to select alternative plans or they will be mapped into Connection plans within the same selected metal tier. If the member's group is located in a county where Connection plans are not available, enrollment will be pended until an alternative plan is selected by the member.</p> <p>To enroll in PPO/EPO or Blue Access plans employees can live/work/reside anywhere in the US.</p>			
<input type="checkbox"/> Platinum EPO 5/25	<input type="checkbox"/> Blue Access Gold EPO 50/55	<input type="checkbox"/> Silver EPO 40/80 <input type="checkbox"/> Silver EPO HSA 4000 <input type="checkbox"/> Blue Access Silver EPO HSA 3250 <input type="checkbox"/> Blue Access Silver EPO 30/75	N/A
 <p>To enroll in Select Care employees must live/work/reside in NY.</p>			
<input type="checkbox"/> Select Care Platinum Premier	<input type="checkbox"/> Select Care Gold Premier	<input type="checkbox"/> Select Care Silver Premier <input type="checkbox"/> Select Care Silver HSA	<input type="checkbox"/> Select Care Bronze HSA <input type="checkbox"/> Select Care Bronze Premier
 <p>To enroll in Metro plans employees must live/work in NY and NJ.</p>			
N/A	<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"/> Metro Silver EPO 30/80 G	<input type="checkbox"/> Metro Bronze HSA 7250 G
 <p>If the group does not meet the Liberty Participation Requirement at open enrollment: the group must either increase their Oxford enrollment to meet the 60% participation OR those enrollees selecting Liberty must select another plan through HealthPass. If an alternative plan is not selected, the Liberty enrollees will be mapped into Metro plans within the same selected metal tier.</p> <p>To enroll in Liberty non-gated plans employees can live anywhere in the continental US.</p> <p>To enroll in Liberty gated (G) plans employees must live in NY, NJ and CT. These members have access to Core Network when they travel or have children attending college outside of the Oxford service area (NY/NJ/CT).</p>			
<input type="checkbox"/> Liberty Platinum EPO	<input type="checkbox"/> Liberty Gold EPO 25/50 ZD <input type="checkbox"/> Liberty Gold EPO 30/60 G <input type="checkbox"/> Liberty Gold HSA 1600 M <input type="checkbox"/> Liberty Gold EPO 30/60	<input type="checkbox"/> Liberty Silver EPO 50/100 ZD <input type="checkbox"/> Liberty Silver EPO 40/80 <input type="checkbox"/> Liberty Silver EPO 30/60 G <input type="checkbox"/> Liberty Silver HSA 4000 M	<input type="checkbox"/> Liberty Bronze HSA 5750

G = Gated, M = Motion, ZD = Zero Deductible

Employee Name:

Group Name/Group #:

H. PCP Selection

\*\*\*NOTE\*\*\* If enrolling in an EmblemHealth 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):	<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 Plus**		
	<input type="checkbox"/> DentalGuard Preferred PPO MAC	<input type="checkbox"/> DentalGuard Preferred PPO 70 UCR	<input type="checkbox"/> DentalGuard Preferred PPO 90 UCR	
<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 #1 \_\_\_\_\_ Dependent #2 \_\_\_\_\_ 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 5 PPO	<input type="checkbox"/> 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 \$1,000 Max, FSA \$2,000 Max, FSA \$3,200 IRS Max)
- Dependent Care Account (DCA) FSA**    Yearly Amount: \$ \_\_\_\_\_ (\$5,000 IRS Max)
- Parking Plan**    Monthly Amount: \$ \_\_\_\_\_ (\$315 IRS Max)
- Transit Plan**    Monthly Amount: \$ \_\_\_\_\_ (\$315 IRS Max)

Please process any mid-year OCA enrollments, changes and terminations through the HealthPass Online Portal (HOP).

M. Life/AD&D

Coverage type (Select one):	<input type="checkbox"/> Employer Paid Life AD&D 50K	<input type="checkbox"/> Employer Paid Life/AD&D 100K
-----------------------------	--	---

Indicate the percent of life insurance proceeds for each beneficiary below (must total 100%):

Beneficiary Name 1*	Relation*	Percent*
Beneficiary Name 2*	Relation*	Percent*

Employee Name:

Group Name/Group #:

**N. Life Plans**

Coverage type (Select one):  Voluntary Life 25K  Voluntary Life 50K

Indicate the percent of life insurance proceeds for each beneficiary below (must total 100%):

Beneficiary Name 1\* Relation\* Percent\*

Beneficiary Name 2\* Relation\* Percent\*

**O. Disability/Life/AD&D**

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\*

**P. 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\*

**Q. Beyond Med**

Coverage type (Select one):  Employee  Family

**R. 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.*

**S. 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).*

## T. 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 am aware the NYHPA/dba HealthPass privacy practices is posted for my review and can be found on [www.healthpass.com](http://www.healthpass.com). 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 \_\_\_\_\_

## U. 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 \_\_\_\_\_

## V. Extra Products & Services

For more valued HealthPass Products & Services visit <https://healthpass.com/extra-products-and-services/> to find out more and enroll.