Health Pass BENEFITS EXCHANGE

2024 ENROLLMENT/CHANGE FORM

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

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):

- ❒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, 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_____

❒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 ❒Employer Paid Life/AD&D 50K ❒Employer Paid Life/AD&D 100K	**❒Life** ❒Voluntary Life 25K ❒Voluntary Life 50K
❒Disability/AD&D/LTD ❒EverGuard ❒EverGuard *Plus*	**❒Accident** ❒Employee ❒Spouse ❒Child(ren)
❒Beyond Med ❒Employee ❒Family	**❒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
Anthem	To enroll in Connection plans employees can live/work/reside anywhere in the US.			
❒Connection Platinum EPO 20/40	❒Connection Gold EPO 25/50 ❒Connection Gold 50/55	❒Connection Silver EPO 40/80	N/A	
Anthem	<u>If the group does not meet the PPO/EPO and Blue Access Requirements at open enrollment</u>: 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.* To enroll in PPO/EPO or Blue Access plans employees can live/work/reside anywhere in the US.			
❒Platinum EPO 5/25	❒Blue Access Gold EPO 50/55	❒Silver EPO 40/80 ❒Silver EPO HSA 4000 ❒Blue Access Silver EPO HSA 3250 ❒Blue Access Silver EPO 30/75	N/A	
EmblemHealth	To enroll in Select Care employees must live/work/reside in NY.			
❒Select Care Platinum Premier	❒Select Care Gold Premier	❒Select Care Silver Premier ❒Select Care Silver HSA	❒Select Care Bronze HSA ❒Select Care Bronze Premier	
United Healthcare Oxford	To enroll in Metro plans employees must live/work in NY and NJ.			
N/A	❒Metro Gold EPO 25/40 ❒Metro Gold EPO 25/40 G	❒Metro Silver EPO 50/100 ZD ❒Metro Silver EPO 30/80 G	❒Metro Bronze HSA 7250 G	
United Healthcare Oxford	<u>If the group does not meet the Liberty Participation Requirement at open enrollment</u>: 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.* 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 Core Network when they travel or have children attending college outside of the Oxford service area (NY/NJ/CT).			
❒Liberty Platinum EPO	❒Liberty Gold EPO 25/50 ZD ❒Liberty Gold EPO 30/60 G ❒Liberty Gold HSA 1600 M ❒Liberty Gold EPO 30/60	❒Liberty Silver EPO 50/100 ZD ❒Liberty Silver EPO 40/80 ❒Liberty Silver HSA 3000 ❒Liberty Silver EPO 30/60 G ❒Liberty Silver HSA 4000 M	❒Liberty Bronze HSA 5750	

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

**Participation requirements do not apply to Mid-Hudson groups (Orange, Putnam, Dutchess, Ulster, Sullivan and Delaware counties).*

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): ❒Employee Only ❒Employee/Spouse ❒Employee/Child(ren) ❒Family

Guardian	❒Managed DentalGuard DHMO**	❒Managed DentalGuard DHMO *Plus***
	❒DentalGuard Preferred PPO MAC	❒DentalGuard Preferred PPO 70 UCR ❒ DentalGuard Preferred PPO 90 UCR
Solstice	❒Dental EPO S700B	❒Dental EPO S800B
	❒Dental PPO	❒Dental Value PPO MAC
UnitedHealthcare	❒National Exclusive Network	❒NO 100/50/50
	❒Low PPO MAC	❒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): ❒Employee Only ❒Employee/Spouse ❒Employee/Child(ren) ❒Family

Coverage type (Select one): ❒Guardian VisionGuard ❒Solstice Vision 5 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 $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): ❒Employer Paid Life/AD&D 50K ❒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

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

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. 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.