HealthPass BENEFITS EXCHANGE

2025 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
❒Young Adult Option
❒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

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 Termination 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 ❒Family
❒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
Mid-Hudson Plans Portfolio - confirm with your employer which plans your group offers.			
Anthem	To enroll in PPO/EPO or Blue Access plans employees can live/work/reside anywhere in the US. PPO/EPO & Blue Access Gated (G) plans - employees can live/reside in the 28-county service area.†		
❒Platinum EPO 5/25	❒Gold EPO 30/65 G ❒Blue Access Gold EPO 50/60 ❒Blue Access Gold EPO 30/65 G	❒Silver EPO 40/80 ❒Silver EPO 40/80 G ❒Silver EPO HSA 4100 ❒Blue Access Silver EPO 35/75 ❒Blue Access Silver EPO 40/80 G ❒Blue Access Silver EPO HSA 3300	N/A
EmblemHealth	To enroll in Select Care plans 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
UnitedHealthcare	To enroll in Choice plans employees can live anywhere in the continental US.		
❒Choice Platinum EPO 15/25 DY-LR ❒Choice Platinum EPO 10/25 DY-LJ ❒Choice Platinum EPO 10/80 DY-MB	❒Choice Gold EPO 40/60 DY-LQ ❒Choice Gold EPO 15/100 DY-MD ❒Choice Gold EPO 30/60 DY-LV ❒Choice Gold EPO 15/30 DY-LK ❒Choice Gold EPO 40/70 DY-LS ❒Choice Gold HSA 1800 DY-LM PR	❒Choice Silver EPO 15/100 DY-MF ❒Choice Silver HSA 3200 DY-LN PR ❒Choice Silver HSA 2750 DY-L7 ❒Choice Silver EPO 30/75 DY-LL	N/A

G = Gated, PR = Premium Rewards

†Anthem PPO/EPO & Blue Access service area consists of five boroughs, Nassau, Suffolk, Westchester, Rockland, Orange, Putnam, Dutchess, Ulster, Sullivan, Delaware, Clinton, Essex, Albany, Columbia, Fulton, Green, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington counties (other New York areas and national access BlueCard Network).

Employee Name: **Group Name/Group #:**

H. PCP Selection

NOTE If enrolling in an Anthem G (gated), 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**	❒DentalGuard Preferred PPO MAC	
	❒Managed DentalGuard DHMO Plus**	❒DentalGuard Preferred PPO 70 UCR	❒ DentalGuard Preferred PPO 90 UCR
Solstice	❒Dental EPO S700B	❒Dental PPO	
	❒Dental EPO S800B	❒Dental Value PPO MAC	
UnitedHealthcare	❒National Exclusive Network	❒Low PPO MAC	
	❒INO 100/50/50	❒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 Plans

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) for initial enrollment:

❒**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 $3,300 IRS Max)

❒**Dependent Care Account (DCA) FSA** **Yearly Amount: $** _____ ($5,000 IRS Max)

❒**Parking Plan** **Monthly Amount: $** _____ ($325 IRS Max)

❒**Transit Plan** **Monthly Amount: $** _____ ($325 IRS Max)

Please process any mid-year OCA enrollments, changes and terminations directly with OCA.

M. Life/AD&D Plans

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 Plans

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 Plans

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 Plan

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 Plan

Coverage type (Select one): ❒Employee ❒Family

This is a discount plan (not insurance).

R. ID Theft Plans

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 ❒Family

Coverage type (Select one): ❒Benefit Elite Plus ❒Benefit Elite Premium

S. Pet Plan

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 are 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.