

Employee Name:

Group Name/Group #:

A. Enrollments/Additions - Complete A, D, E, O, P and select coverages F-N

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"/> Young Adult Option |
| <input type="checkbox"/> Date of Birth ___/___/___ | <input type="checkbox"/> Status Change (part-time to full-time) ___/___/___ | <input type="checkbox"/> Other _____ |
| <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. Change Requests - Complete B, O, P and list changes in D, E

Requested Effective Date:

Change Type:

___/___/___

- Name Change Address Change Other _____

C. Terminations - Complete C, D, E, O, P. Termination date must be the last day of the month.

Requested Termination Date:

Reason:

___/___/___

- No Longer Employed Cancel All Coverage Other _____

Dental

- Employee Spouse Child(ren)

Vision

- Employee Spouse Child(ren)

Life/AD&D

- Employer Paid Life/AD&D 50K Employer Paid Life/AD&D 100K

Life

- Voluntary Life 25K Voluntary Life 50K

Disability/Life/AD&D

- EverGuard EverGuard Plus

Accident

- Employee Spouse Child(ren)

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 E those who should have their coverage terminated. NOTE - If no child(ren) are separately listed in Section E, ALL dependent children on the policy will be terminated.

D. 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*					

E. 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 #:

Confirm with your employer which products and plans are available for enrollment.

F. Dental Packages

Waive Coverage

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

Dental Package 1 - No Participation Requirements Apply

- Guardian Managed DentalGuard DHMO Solstice Dental PPO
 Guardian Managed DentalGuard DHMO Plus Solstice Dental Value PPO MAC
 Solstice Dental EPO S700B UnitedHealthcare National Exclusive Network
 Solstice Dental EPO S800B

Dental Package 2 - Participation Requirements Apply

- Guardian Managed DentalGuard DHMO Solstice Dental PPO
 Guardian Managed DentalGuard DHMO Plus Solstice Dental Value PPO MAC
 Guardian DentalGuard Preferred PPO MAC UnitedHealthcare National Exclusive Network
 Guardian DentalGuard Preferred PPO 70 UCR UnitedHealthcare INO 100/50/50
 Guardian DentalGuard Preferred PPO 90 UCR UnitedHealthcare Low PPO MAC
 Solstice Dental EPO S700B UnitedHealthcare High PPO MAC
 Solstice Dental EPO S800B

G. 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 _____

H. Vision Plans

Waive Coverage

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

I. Life/AD&D Plans

Waive Coverage

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*

J. Life Plans

Waive Coverage

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*

K. Disability/Life/AD&D Plans

Waive Coverage

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*

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Group Name/Group #:

L. Accident Plan Waive Coverage

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.

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

Beneficiary Name 1* Relation* Percent*

Beneficiary Name 2* Relation* Percent*

M. ID Theft Plans Waive Coverage

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

N. Pet Plan Waive Coverage

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).

O. Employee Signature

I hereby apply for the 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 am aware to access the Ancillary Exchange I am required to pay a \$2.00 Per Employee Per Month (PEPM) Exchange Access Fee. 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 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 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 at 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 _____

P. 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 _____

Q. Extra Products & Services

To enroll in Beyond Med, a membership program that elevates health and well-being by providing access to a proprietary network of board-certified doctors and licensed providers at reduced rates on elective and cosmetic services, visit <https://www.beyondmedplans.com/groups/healthpass>.

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