

Instructions

1. Determine whether you want to enroll, decline coverage, or change information and complete the corresponding box.
 2. Complete the section entitled “*General Information.*”
 3. If you have life coverage, complete the beneficiary information in the section entitled “*Life Insurance.*”
 4. If you are electing FBA coverage, complete the section entitled “*Flexible Benefit Account.*”
 5. If you are electing medical or dental coverage, complete the section entitled “*Medical and Dental Coverage.*”
 - If you select the HMO or POS plan, be sure to select a Primary Care Physician (PCP) for yourself and each covered dependent. Your PCP will coordinate your medical care, providing most services and referring you to hospitals and specialists when necessary.
 - If you select the PPO plan, do not supply provider information.
- If you need help selecting a PCP, contact Member Services.
6. Read the “*Disclosure Information*” on the back of the application.
 7. Sign and date the application.
 8. Remove this instruction card, keep the pink copy for your records and turn in the completed application to your plan administrator.

We look forward to meeting your family’s health care needs.

Benefit Plan Enrollment/Change Form

ENROLLING				DECLINING COVERAGE		CHANGING INFORMATION																																									
Enrollment for: <input type="checkbox"/> Myself and my dependents (family coverage) <input type="checkbox"/> Myself only (single coverage) because: <input type="checkbox"/> I have no dependents <input type="checkbox"/> My dependents have other insurance <input type="checkbox"/> I don't wish to purchase dependent coverage		Plan Selections: <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th>Medical</th> <th>Ee</th> <th>Ee & Sp</th> <th>Ee & Ch</th> <th>Family</th> <th>Dental</th> <th>Ee</th> <th>Ee & Sp</th> <th>Ee & Ch</th> <th>Family</th> </tr> </thead> <tbody> <tr> <td>HMO</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Dental+</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>POS</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Indemnity Dental</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>PPO</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>POS Dental</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </tbody> </table>		Medical	Ee	Ee & Sp	Ee & Ch	Family	Dental	Ee	Ee & Sp	Ee & Ch	Family	HMO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dental+	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	POS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Indemnity Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PPO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	POS Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reason: <input type="checkbox"/> I have other insurance <input type="checkbox"/> Other _____ My signature below certifies that I understand the availability of health coverage.		<input type="checkbox"/> Updating General Information <input type="checkbox"/> Transferring to a different plan <input type="checkbox"/> Changing PCPs <input type="checkbox"/> Adding a dependent <input type="checkbox"/> Changing FBA salary redirection amount	
Medical	Ee	Ee & Sp	Ee & Ch	Family	Dental	Ee	Ee & Sp	Ee & Ch	Family																																						
HMO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dental+	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																						
POS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Indemnity Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																						
PPO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	POS Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																						
General Information (always complete this section)				Life Insurance		Flexible Benefit Account																																									
Name Last First MI		Occupation		If your employer is paying the full cost for this coverage, you are automatically covered under this benefit.		Premiums will be deducted from my paycheck on a before-tax basis. I give my employer permission to reduce my salary by the following election amounts. FBA premiums are in addition to medical premiums deducted.																																									
Street		Daytime Telephone (____) _____		Evening Telephone (____) _____		<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th>Beneficiary</th> <th>Relationship</th> <th>%</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td></td> <td></td> </tr> <tr> <td>2.</td> <td></td> <td></td> </tr> </tbody> </table>		Beneficiary	Relationship	%	1.			2.																																	
Beneficiary	Relationship	%																																													
1.																																															
2.																																															
City State Zip Code		May we contact you? <input type="checkbox"/> Yes <input type="checkbox"/> No		Email address _____		Eligible Health Care Expenses (annual) <input type="checkbox"/> I wish to redirect: \$ _____ employee's election amount \$ _____ employer's contribution (if any) <input type="checkbox"/> I do not wish to redirect any money for health care expenses																																									
County Social Security Number		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		<input type="checkbox"/> Single <input type="checkbox"/> Married Date of Marriage ____/____/____ Primary Language _____		Eligible Dependent Care Expenses (annual) <input type="checkbox"/> I wish to redirect: \$ _____ employee's election amount \$ _____ employer's contribution (if any) <input type="checkbox"/> I do not wish to redirect any money for dependent care expenses																																									
Do you have a disability that could affect your ability to read or communicate? <input type="checkbox"/> Yes <input type="checkbox"/> No		<p>If you are applying for any Great-West coverage, including life coverage, you must answer the following question. You will not be individually denied coverage, or be charged different rates as a result of your answer. This information is <u>not</u> required if you are only applying for HMO medical coverage.</p> <p>During the last 24 months, have you or any dependents been diagnosed with, or treated for, any adverse health conditions, including cancer, heart, lung, kidney, or liver diseases, diabetes, AIDS, ARC, brain disorders, or received an organ transplant, or incurred medical expenses which accumulated to more than \$10,000 or been scheduled for surgery or an organ transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No Condition? _____</p>																																													
Medical and Dental Coverage																																															
Name (Last, First, M.I.)	Date of Birth/Relationship	Sex	Full-time Student	Primary Care Physician (Last, First, M.I.) Please list name(s) exactly as they appear in the directory		Existing Patient?																																									
Self	/ /	<input type="checkbox"/> M <input type="checkbox"/> F		PCP	Medical Group	<input type="checkbox"/> Yes <input type="checkbox"/> No																																									
				Address																																											
Spouse	/ /	<input type="checkbox"/> M <input type="checkbox"/> F		PCP	Medical Group	<input type="checkbox"/> Yes <input type="checkbox"/> No																																									
Social Security Number				Address																																											
Child	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	PCP	Medical Group	<input type="checkbox"/> Yes <input type="checkbox"/> No																																									
Social Security Number				Address																																											
Child	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	PCP	Medical Group	<input type="checkbox"/> Yes <input type="checkbox"/> No																																									
Social Security Number				Address																																											
Child	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	PCP	Medical Group	<input type="checkbox"/> Yes <input type="checkbox"/> No																																									
Social Security Number				Address																																											
By my signature below, I acknowledge that I have read and understand the disclosure on the back of this application. I authorize the required payroll deduction for contributory benefits. I also represent that all information shown on this application is correct.																																															
Employee Signature				Date (MM/DD/YYYY)																																											
To be Completed by Employer																																															
Company Name																																															
Date of Full-time Employment		Div/Location																																													
Orig. Eff. Date of EE's Coverage		Orig. Eff. Date of Dep's Coverage																																													
Earnings \$ _____				<input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-Monthly <input type="checkbox"/> Yearly																																											
Hours worked per week? _____				Is employee/dependent on COBRA continuation? <input type="checkbox"/> Yes <input type="checkbox"/> No																																											
If Yes, attach copy of original COBRA enrollment form.																																															
For Carrier Use Only																																															
Plan Number				Effective Date																																											
Division		Late App		Class/Benefit Group																																											

Disclosure Information

I hereby apply for all non-contributory coverages under my employer's plan and any contributory coverages that I have elected on the front of this application.

Life and/or disability income coverage

I understand that I must satisfy the eligibility and actively at work requirements at my employer's usual place of business on the date coverage for myself and any eligible dependents becomes effective. If I am not actively at work, I understand that coverage for myself and life coverage for my eligible dependents may not become effective until I return to work. I will be considered a late applicant if I decline any contributory coverage offered under this application and later apply. As a late applicant applying for coverage, I understand that proof of good health may be required for myself and eligible dependents.

FBA Coverage

If I have elected to redirect money for eligible dependent care expenses, I have considered the IRS tax credit available to me. I understand that if I am married and filing a separate tax return, a lower maximum applies.

Health coverage

I understand that I must submit a Certificate or evidence of prior creditable coverage to receive credit towards the satisfaction of any pre-existing condition limitation specified in my employer's plan; and to be eligible for credit, the gap between the two coverages must be 63 days or less.

I and/or my eligible dependent(s) will be considered a "Special Applicant" if:

- I did not previously elect to cover myself and/or my eligible dependent(s) under my employer's policy/plan because of other health coverage and I later apply because the other coverage terminated involuntarily; or
- I did not previously elect to cover myself and/or my eligible dependent(s) and I later apply for coverage because of a change in my family status resulting from marriage, birth or adoption of a child.

I understand that to qualify as a "Special Applicant" I must apply for health coverage for myself and/or my eligible dependent(s) within 31 days after:

- Coverage under the prior health plan ends; or I marry; or I acquire a new child through birth, adoption or placement of a child for adoption.

I will be considered a late applicant if:

- I fail to qualify as a "Special Applicant" because I did not apply within the 31 days as specified above; or
- I did not previously elect to cover myself and/or my eligible dependents and I later apply.

As a late applicant applying for health coverage, I realize that I may only be allowed entrance to the plan during the open enrollment period. As a late applicant, I realize that my entry to the plan may be subject to special enrollment requirements and that I must contact my Plan Administrator for details.

HMO coverage - One Health Plan seeks information regarding primary language and disabilities from its Members in order to provide those services necessary to meet Members' various needs, including access to enrollee and health care information and health care services.

For all coverages

I hereby authorize any insurance company, health care provider, or other entity or person having knowledge of anyone listed on this application to give this new carrier or their designated agent(s) any and all records pertaining to such person's medical history for purposes of review, investigation or evaluation. For application purposes, this authorization is valid for 30 months from the date I sign it. For purposes of claims, reimbursement and receipt of services rendered, this authorization is valid during the term of such person's coverage for evaluation of the nature and medical necessity of the services received. I am, or my authorized representative is, entitled to a copy of this signed authorization.

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

This Disclosure Information forms a part of the *Application for Membership* as fully as if it were contained over the applicant's signature.