



Enrollment / Change Form

Effective date for action requested below
 _____ / _____ / _____
 (New Groups 1st or 15th of the Month Only)

HealthPass
 7120 Lake Ellenor Drive
 Orlando, FL 32809-5721
 Member Services: (888) 313-7277
 Billing: (888) 313-7010
 Fax: (888) 354-7277

Enrollment / Additions

Group Open Enrollment
 Medical Dental EverGuard

New Employee

Status Change (PT to FT) on _____ / _____ / _____

Involuntary loss of coverage _____ / _____ / _____

Add Dependent
 Birth on _____ / _____ / _____
 Marriage on _____ / _____ / _____
 Adoption (Attach Legal Document)

Other (describe) _____

Terminations / Changes

Cancellations
 Medical Dental EverGuard

Cancel Dependents listed below in Section D

Changes: Check off below and fill in sections C&I.
 New Street Address
 New Home Phone
 New Name
 Other _____

Continuation-of-Coverage / COBRA
IMPORTANT! Please remit COBRA payment with application directly to HealthPass.

Employee Election
 Dependent(s) Election

Start date _____ / _____ / _____
 Stop date _____ / _____ / _____

Qualifying Event & Date

Termination/Loss of Eligibility _____
 Death of Covered Employee _____
 Dependent Child Limiting Age _____
 Other _____

A Waiving Coverage **To waive coverage, complete Sections A, C, I, and J.**

Waive Health I am waiving Health coverage. I understand I will not be able to enroll without a qualifying event until my employer's next open enrollment. Reason for waiving coverage: Covered by other plan Not Interested

Name of Insurer _____ / _____ / _____ Name of Policyholder _____ / _____ / _____ Policy ID# _____ Effective Date _____ / _____ / _____

Waive Dental I am waiving the following Dental coverage: Myself Spouse Child(ren)

B Prior Coverage **Failure to indicate prior coverage may result in claims issues.**

Name of Insurer _____ / _____ / _____ Name of Policyholder _____ / _____ / _____ Policy ID# _____ Effective Date _____ / _____ / _____ Term Date _____ / _____ / _____

C Employee Information **All information must be provided for enrollment.**

Are you an owner of the company? Yes No

Company Name _____ Date of FT Hire _____ / _____ / _____ Hrs. Worked Per Week _____ Actively at Work
 Retired

Employee Name (Last, First, Middle Initial – PLEASE PRINT) _____ Social Security # _____ Male
 Female

Street Address _____ Apt # _____ City _____ State _____ Zip _____

Home Phone () _____ Business Phone () _____ Birth Date (MM/DD/YY) _____ / _____ / _____ Single Married Divorced

If you are selecting a plan from HIP or Health Net, please also select a primary care physician.

Dr. Name: _____ ID# _____

D Dependent Information **List all Dependents** (Last Name, First, Middle Initial)

Spouse* (Last, First, Middle Initial) M F Birth Date (MM/DD/YY) _____ / _____ / _____ Social Security # _____ / _____ / _____

Dr. Name: _____ ID# _____

Dep # 1 (Last, First, Middle Initial) M F Birth Date (MM/DD/YY) _____ / _____ / _____ Social Security # _____ / _____ / _____

Dr. Name: _____ ID#: _____ ****If over age 19, are you a full-time student?** Yes No

Dep # 2 (Last, First, Middle Initial) M F Birth Date (MM/DD/YY) _____ / _____ / _____ Social Security # _____ / _____ / _____

Dr. Name: _____ ID#: _____ ****If over age 19, are you a full-time student?** Yes No





Dep # 3 (Last, First, Middle Initial) M F Birth Date (MM/DD/YY) _____ / _____ / _____ Social Security # _____ / _____ / _____

Dr. Name: _____ ID#: _____ ****If over age 19, are you a full-time student?** Yes No

*Spouses enrolling under a different last name must provide a copy of their marriage certificate. Domestic Partner Coverage through GHI, HIP and Guardian only. See eligibility guidelines.
 **Students must submit verification of full-time status.
 Online form(s) available at www.healthpass.com

E Type of Medical Coverage : Employee Only Employee and Spouse Employee and Child(ren) Family
 Please check if enrolling a Domestic Partner

F Medical Plan Options

	In-Network Only	In & Out of Network	Cost Sharing	HSA Plans
 Group Health Incorporated Mandatory Mail Order For Maintenance Rx	<input type="checkbox"/> HP Standard 15 <input type="checkbox"/> HP Standard 20 <input type="checkbox"/> GHI EPO 20 Plus <input type="checkbox"/> GHI EPO 30 Plus <input type="checkbox"/> GHI EPO 40 Plus	<input type="checkbox"/> HP Flexible 15 <input type="checkbox"/> HP GHI PPO 30	<input type="checkbox"/> GHI EPO Share 40 Plus	<input type="checkbox"/> HSA EPO Index
 Health Net®	<input type="checkbox"/> HP Standard 15 <input type="checkbox"/> HP Standard 20 <input type="checkbox"/> HealthNet HMO 25 <input type="checkbox"/> HealthNet EPO 30	<input type="checkbox"/> HP Flexible 15 <input type="checkbox"/> Health Net POS 25	<input type="checkbox"/> Health Net EPO Share 25	<input type="checkbox"/> HSA POS 4500
 HEALTH PLAN OF NEW YORK Referral Required	<input type="checkbox"/> HP Standard 15 <input type="checkbox"/> HP Standard 20 <input type="checkbox"/> HIP HMO 5 <input type="checkbox"/> HIP HMO 25	<input type="checkbox"/> HP Flexible 15 <input type="checkbox"/> HIP POS 25	<input type="checkbox"/> HIP EPO 100/90 New <input type="checkbox"/> HIP EPO 100/80 3k <input type="checkbox"/> HIP PPO Share 30	Not Available
 PerfectHealth Insurance Company	Not Available	Not Available	Not Available	<input type="checkbox"/> HSA PPO 5000G <input type="checkbox"/> HSA PPO 2500P

G Dental Plan Options Note: If your employer is offering Dental coverage, please indicate the coverage(s) desired. Effective date 1st of month only.



Managed DentalGuard (DMO) DentalGuard Preferred (PPO)
 Employee Only Employee and Spouse Employee and Child(ren) Family
 Please check if enrolling a Domestic Partner

Please select Dental Facility ID# for DMO Coverage:

Employee: _____ Spouse/Domestic Partner: _____ Dep.#1: _____ Dep.#2: _____ Dep.#3: _____

H EverGuard Plan Option Note: You may only elect the coverage level offered by your employer. If electing coverage, please indicate beneficiary(ies). Available to employees only (no dependents).



I am electing EverGuard I am electing EverGuard Plus

Select up to two beneficiaries. Indicate the percent of life insurance proceeds for each beneficiary. Must total 100%.

Beneficiary Name	Relation	Percent	Beneficiary Name	Relation	Percent
#1: _____	/	/ %	#2: _____	/	/ %

I Employee Signature

I hereby apply for the health insurance company and benefit plan 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 the family members indicated on this form with the medical and dental 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 medical or dental 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.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. See eligibility guidelines. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you 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 me and remit same to HealthPass. (The subscriber is responsible for the total cost of care received 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 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 _____ Date _____ / _____ / _____

J Employer Signature Form must be signed and dated by an Authorized Company Representative.

I certify that the person(s) presented on this form are eligible employees (or dependents) and work for the employer identified on this form.

Signature _____ Date _____ / _____ / _____ Group # _____
 Authorized Company Representative (if enrolled)