# HEALTH BENEFIT PLAN ENROLLMENT FORM

**COMPLETE ALL SECTIONS BELOW FOR NEW ENROLLMENTS. INCOMPLETE FORMS WILL BE RETURNED. PLEASE REVIEW THE STATEMENT OF HIPAA PORTABILITY RIGHTS ON THE BACK.**

**Company / Employer Name:**

EMPLOYEE NAME (FIRST) (INITIAL) (LAST)

Type of Benefits:
☐ Medical ☐ Vision ☐ Disability
☐ Dental ☐ Life ☐ Other:

ADDRESS

SOCIAL SECURITY NO. (required by law) _____ SEX (M OR F) _____ BIRTH DATE _____

CITY STATE ZIP

**DATE OF HIRE** _____ ☐ Single ☐ Widowed ☐ Divorced ☐ Married

**HOME PHONE NUMBER**

**WORK PHONE NUMBER**

**OCCUPATION/JOB TITLE** _____

**EARNINGS (IF APPLICABLE)** **$_____PER_____**

**E-MAIL ADDRESS**

**FOR COMPANY USE ONLY**

**PLAN#** **DEPT.** **EFFECTIVE DATE**

BENEFICIARY (FIRST) (INITIAL) (LAST) | BIRTHDATE | RELATIONSHIP

ADDRESS

(STREET) (CITY) (STATE) (ZIP) | (AREA CODE) PHONE NUMBER

**DEPENDENTS (Use additional paper, if necessary)**

| FIRST INITIAL LAST | SOCIAL SECURITY NUMBER | BIRTH DATE | SEX | RELATIONSHIP | RESIDES WITH EMPLOYEE YES / NO | | TO BE COVERED YES / NO | |
|---|---|---|---|---|---|---|---|---|
| **LEGAL SPOUSE** Marriage Date: _____ | | | | | ☐ | ☐ | ☐ | ☐ |
| List Child | | | | | ☐ | ☐ | ☐ | ☐ |
| List Child | | | | | ☐ | ☐ | ☐ | ☐ |
| List Child | | | | | ☐ | ☐ | ☐ | ☐ |
| List Child | | | | | ☐ | ☐ | ☐ | ☐ |
| List Child | | | | | ☐ | ☐ | ☐ | ☐ |
| List Child | | | | | ☐ | ☐ | ☐ | ☐ |

Any dependents listed above must meet the definition of a dependent as listed in the Summary Plan Description.

If a dependent child is over the age of 19 & (if your plan requires this) is he/she a full time student/volunteer? ☐ Yes ☐ No. If yes, please indicate the name of the school/volunteer organization:

I UNDERSTAND that providing inaccurate or incorrect information to any of the questions on the Enrollment Form may be considered health care fraud.

I HEREBY AUTHORIZE my employer to make any required payroll deductions for this coverage. I certify that the information provided is true and correct.

**SIGNATURE OF APPLICANT** **DATE**

***COMPLETE WAIVER FORM ON BACK IF YOU AND/OR YOUR DEPENDENTS CHOOSE NOT TO BE COVERED BY THIS HEALTH BENEFIT PLAN***

## *HEALTH COVERAGE WAIVER FORM*

**(Complete Waiver only if you are waiving coverage for yourself & / or any dependent)**

| **COMPANY / EMPLOYER NAME:** | **GROUP NUMBER** |
|---|---|
| **EMPLOYEE NAME: (**LAST) (FIRST) (INITIAL) | **SOCIAL SECURITY NUMBER** |

**I decline to enroll in the health coverage for:**

☐ Myself ☐ My Spouse Reason for waiver: ☐ The existence of other coverage _____ (Plan Name)

☐ My Dependent Child/Children (please list below) ☐ Other reason (explain)_____

1._____ 2._____

3._____ 4._____

5._____ 6._____

I understand that this waiver of coverage may affect the ability of each person listed above to obtain coverage at a later date. Specifically, except during applicable "Special Enrollment Periods", each person listed above may be considered to be a Late Enrollee, and subjected to an exclusionary period of up to eighteen (18) months for any pre-existing condition, as that term is defined by Federal Law (HIPAA).

EMPLOYEE'S SIGNATURE _____ DATE SIGNED _____

SPOUSE'S SIGNATURE _____ DATE SIGNED _____
(If Spouse is waiving coverage)

**Statement of HIPAA Portability Rights**

**Pre-existing condition exclusions.** Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "pre-existing condition exclusions." A pre-existing condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a specified period of time before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period. In addition, a pre-existing condition exclusion cannot last for more than 12 months after your enrollment date (in some cases, 18 months if you are a late enrollee.) Finally, a pre-existing condition exclusion cannot apply to pregnancy or genetic information and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

If a plan imposes a pre-existing condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and coverage through high-risk pools and the Peace Corps. If you do not receive a certificate for past coverage, talk to your new plan administrator.

You can add up any creditable coverage you have. However, if at any time you went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

**Right to get special enrollment in another plan.** Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment according to the Special Enrollment provisions of your plan (usually within 30 or 60 days). (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

- Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

**Prohibition against discrimination based on a health factor.** Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

**Right to individual health coverage.** Under HIPAA, if you are an "eligible individual," you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a pre-existing condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan;
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
- You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.

- Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

**I ACKNOWLEDGE that I have read the statement of HIPAA Portability Rights.**

**I have prior creditable coverage ☐ Yes ☐ No. If yes, I understand I must submit a certificate of creditable coverage to Allegiance Benefit Plan Management, Inc.**

# OTHER HEALTH INSURANCE INFORMATION

**Other Health Coverage?** ___ **Yes (complete below)** ___ **No**
**(* Please do not include coverage this plan is replacing unless you will continue to be covered under your existing plan)**

Please check the coverage currently being provided elsewhere: ___ Medical ___ Dental ___ Vision ___ Pharmacy
List all family members, including yourself, who are covered by other health coverage at the present time:

| **SELF:** ___ Yes ___ No | **Spouse:** ___ Yes ___ No | **Child/Children:** ___ Yes ___ No |
|---|---|---|

If you checked **YES** please list dependents below:

| SPOUSE: | Date coverage will end: | CHILD: | Date coverage will end: |
|---|---|---|---|
| CHILD: | Date coverage will end: | CHILD: | Date coverage will end: |
| CHILD: | Date coverage will end: | CHILD: | Date coverage will end: |

| Provide name, phone number and address of your other insurance company: | Policy/Certificate Number: | Effective Date: |
|---|---|---|
| Policyholder's name: | Social Security Number: | Date of Birth: |

**If you and/or your dependents are enrolled in Medicare Part A, Part B, &/or Part D or Medicaid, please complete the following:**

| Enrollee's name(s): | Medicare/Medicaid ID#: | Medicare Part A Effective Date: | Medicare Part B Effective Date: | Medicare Part D Effective Date: | Medicaid Effective Date: |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

Have you and/or your dependents been covered by a plan administrated by Allegiance Benefit Plan Management, Inc. in the past two years?
___ Yes **(complete below)** ___ No

| Group Name: | Group Number: |
|---|---|