



Health Net

# Enrollment / Change / Waiver Form

GROUP NAME: \_\_\_\_\_ GROUP ID: \_\_\_\_\_ EFFECTIVE DATE: \_\_\_/\_\_\_/\_\_\_

MEDICAL PLAN: \_\_\_\_\_

New Enrollment  Enrollment Change  Address Change  Name Change Reason: \_\_\_\_\_

**Enrollment Reasons:** New Employee, Rehired Employee, Open Enrollment, Transfer From Other Plan Offered by Group, Employee Entered Eligible Class (Part-time to Full-time, Temporary to Permanent, Job Title Change), Marriage, Divorce, Death, Birth, Adoption (Legal Documents May Be Required), Dependent Change, and Involuntary Loss of Other Coverage (Prior Coverage Certificate required)

**1. GROUP INFORMATION (TO BE COMPLETED BY THE GROUP):** Date of Hire \_\_\_/\_\_\_/\_\_\_ or Employee entered eligible class on \_\_\_/\_\_\_/\_\_\_ Reason: \_\_\_\_\_

Job Title: \_\_\_\_\_ Hours Per Week: \_\_\_\_\_ Work Location: \_\_\_\_\_ Class \_\_\_\_\_

**2. EMPLOYEE INFORMATION (EMPLOYEE TO COMPLETE SECTIONS 2-9)** Date of Birth \_\_\_/\_\_\_/\_\_\_ Gender:  Male  Female

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Social Security Number: \_\_\_\_\_ --\_\_\_\_--

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Mailing Address (if Different) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Business Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Email \_\_\_\_\_

**3. DEPENDENT ENROLLMENT INFORMATION** Notes: Please check the Enroll or Delete box for each enrollee. Use a separate sheet to list additional enrollees. **If Waiving Coverage go to Section 8.**

Medical		Relationship to Employee	Name (Last, First, MI)	Social Security Number**	Gender M/F	BirthDate (MO/Day/YR)	Date of Event***
Enroll	Delete						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Spouse/State Reg DP* <input type="checkbox"/> Domestic Partner					
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						

\* Domestic Partner

\*\* Federal regulation requires this information for enrollment

\*\*\* Date of Marriage, Divorce, Adoption, Death, or Loss of Coverage

Is any child over the dependent age limit of 26 applying for coverage eligible due to disability?  No  Yes, complete and attach the Request for Certification of Disabled Dependent.

## 4. MEDICARE FOR EMPLOYEE AND ALL DEPENDENTS

Is any person applying covered by Medicare?  No, go to section 5  Yes, please complete the following:

Name \_\_\_\_\_ Medicare ID # \_\_\_\_\_ Effective Date: Part A \_\_\_/\_\_\_/\_\_\_ Part B \_\_\_/\_\_\_/\_\_\_ Reason:  Age  Disability  End Stage Renal Disease

Name \_\_\_\_\_ Medicare ID # \_\_\_\_\_ Effective Date: Part A \_\_\_/\_\_\_/\_\_\_ Part B \_\_\_/\_\_\_/\_\_\_ Reason:  Age  Disability  End Stage Renal Disease

# Enrollment / Change / Waiver Form (continued)

## 5. CONTINUED COVERAGE FOR SPOUSE/State Registered DP AND DEPENDENTS

Is your spouse/State Registered DP or child applying for continued coverage?  No  Yes, complete and attach a COBRA Enrollment Form.

## 6. PRIOR COVERAGE FOR ENROLLING EMPLOYEE AND ALL DEPENDENTS

Have you and/or eligible dependents had other medical coverage in the past six (6) months?

No, go to section 7  Yes, please complete the following section: **Notes:** Some Groups have a waiting period before an employee is eligible for benefits. If you are not sure of your enrollment date, please contact your Group Benefits Administrator. Use a separate sheet to list additional prior carrier coverage.

Prior Plan Name \_\_\_\_\_ Prior Plan Phone Number ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Date Coverage Began \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Subscriber ID Number \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Names of all Person(s) Covered \_\_\_\_\_

Will this coverage be in effect after the coverage with this plan begins?  Yes  No, enter date coverage ended \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## 7. OTHER COVERAGE FOR ENROLLING EMPLOYEE AND ALL DEPENDENTS *Helpful Hint: Failure to complete prior coverage information could affect payment of claims.*

Will any person applying for coverage be covered under another plan after the coverage with this plan begins?  No, go to section 8  Yes, complete the following section:

Other Plan Name \_\_\_\_\_ Other Plan Phone Number ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Date Coverage Began \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Subscriber ID Number \_\_\_\_\_

Birthdate of Insured \_\_\_\_\_ Name of Insured \_\_\_\_\_ Names of all Person(s) Covered \_\_\_\_\_

Is this person covered as a retired or laid-off employee or is this person a covered dependent of such an employee?  No, go to section 8  Yes, enter the date retired or laid-off \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**8. DECLINING COVERAGE:** This is to confirm that I decline to participate in the Health Coverage program offered through my employer's group plan as follows:

Medical:  I do not wish to enroll myself. I have other medical coverage. **(Please Note: If your company offers Vision coverage, Vision enrollment must match Medical enrollment.)**

I do not wish to enroll myself. I do not have other medical coverage.

I do not wish to enroll my  spouse/State Registered DP  children.\* They have other medical coverage.

I do not wish to enroll my  spouse/State Registered DP  children.\* They do not have other medical coverage.

\*Please list the names of specific children you wish to waive if you are not enrolling all of them: \_\_\_\_\_

If you are declining health coverage enrollment for yourself or dependents (including your spouse/State Registered DP) because of other coverage, you may in the future enroll yourself or your dependents in this plan prior to the next open enrollment period. To do this, you must have **involuntarily** lost your other coverage and we must receive your enrollment application within 30 days after your other coverage ended. Additionally, 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 dependents, provided we receive your completed enrollment application within the time period allowed (see your Certificate). If you request coverage for yourself and/or eligible dependents at a later date, coverage may be subject to late enrollment penalties.

**9. EMPLOYEE SIGNATURE** In applying for enrollment as indicated on this application, I declare that to the best of my knowledge all of the information on this form is true and complete, and all of the persons for whom I am requesting enrollment are eligible for coverage. The changes on this form supersede all previous forms submitted. I authorize my employer to deduct from my earnings the amount, if any, for the coverage selected. The Subscriber Group and the company may collect, use and disclose protected personal information (PPI) about each individual enrolled under this Application in order to carry out its routine business functions, which, but are not limited to, determining eligibility for benefits, paying claims, coordinating benefits with other carriers or payers, underwriting, and conducting case management, care management and quality reviews. The company may also disclose PPI to state and/or federal agencies, or other third parties, as required by law.

IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.

Employee Signature \_\_\_\_\_ Date Signed \_\_\_\_ / \_\_\_\_ / \_\_\_\_