1.01.12 - 3.15.12 New/Existing Groups Only



All provider changes must be done through the carrier directly.

Enrollment / Change Form

New/Existing Groups Effective: 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 Vision EverGuar New Employee Status Change (PT to FT) on / / Involuntary loss of coverage / / Add Dependent Birth on / / Marriage on / / Adoption (Attach Legal Document) Other (describe)	☐ Cancel Depend ☐ Changes: Check sections C&J. ☐ New Street A ☐ New Home P ☐ New Name ☐ Other	voluntary ntal	Continuation-of IMPORTANT! Payr	ection /
Waiving Coverage (complete Section				
By waiving coverage, I understan Health / Reason: Covered Name of Insurer	d I will not be able to enr by other plan Name of Policyholder /	oll without a qualifying event u Not interested – no other Policy ID#	coverage	xt open enrollment. Effective Date
	by other plan by other plan	☐ Not interested – no other☐ Not interested – no other		
	ailure to indicate prion f Policyholder /	or coverage may result in c Policy ID# /	laims issues. Effective Date	Term Date
Employee Information Are you an owner of the company? Company Name		De provided for enrollment	:• 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/Cell Phone Bu	siness Phone	Birth Date (MM/DD/	(Y) ☐ Single	☐ Married ☐ Divorced
If you are selecting a plan from Compre Dr. Name:	eHealth or the Oxford Li	berty HMO please also select	a primary care physi	ician.
Dependent Information Spouse* (Last, First, Middle Initial)	ist all Dependents (La □M □ F	nst Name, First, Middle Initial) 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#:			
Dep # 2 (Last, First, Middle Initial)	□M□F	Birth Date (MM/DD/	YY)	Social Security #
Dr. Name:	ID#:			
Dep # 3 (Last, First, Middle Initial)	□M□F	Birth Date (MM/DD/	YY)	Social Security #
Dr. Name:	ID#:			

Online form(s) available at www.healthpass.com

Modical Dis-		Please check if enrolling a Domes	stic Partner		
🥊 ivieuicai Piai	n Options				
<u> </u>	In-Network Only	Cost-Sharing			
	☐ EH EPO 40-10001K/50%-New	☐ EH EPOcs 40-2500 1K/50%			
	CompreHealth HMO 30/50-1000				
	☐ CompreHealth HMO 30/50-1000 G (CompreHealth is for NY residents only, network is				
Emblem Health	limited to 5 Boroughs, Long Island, and Westchest	er)			
		T LID FDO 20/50 4500 N			
HIP	Not Available	☐ HP EPOcs 30/50-1500 New ☐ HIP PPOcs 30/50-2000/2500			
HEALTH PLAN OF NEW YORK					
	☐ Ox Freedom EPO 50-500(2500max)	☐ Ox Liberty EPOcs 25/50-2000			
	Ov Liberty HMO 30/50-500(1000may				
© OXFORD		☐ Ox USA PPOcs 25/40-1000/20)00		
Dantal Blan (Options Note: If your employer is of				
Dental Plan (st or month only.
GUARDIA			☐ DentalGuard Preferred (F		
CIOARDIA	- Managed De		☐ DentalGuard Preferred P		
	☐ Employee Or	nly ☐ Employee and Spouse ☐ Please check if enrolling) □ Family	
Please se	elect Dental Facility ID# at initial enroll	Iment only for DMO Coverage:	a Domestic Partner		
	Constant Description Des		Dan #0.	D #2.	
Employee		artner: Dep.#1:		Dep.#3:	
•	Option Note: This is a 24 month cont		tive date. Coverage can only	be cancelled at the	completion of 2
years or if all Health	hPass coverage is cancelled. Effective				
G	☐ I am electing	nly	☐ Employee and Child(ren)	
GUARDI	AN'	☐ Please check if enrolling		, = . u y	
EverGuard Pla	an Ontions Note: You may only a	elect the coverage level offered b	y vour employer If electing	a coversae inlesse ir	dicato
y Everouuru ric	•	s). Available to employees only (r		g coverage, piease ii	laicate
G			io dependents).		
GUARDIA	AN ^r □ I am electing	g EverGuard 🗖 I am elec	cting EverGuard <i>Plus</i>		
Select up to two be	neficiaries. Indicate the percent of life	insurance proceeds for each be	neficiary. Must total 100%.		
D 6' - ' 1	Relation	Percent Beneficiary	[,] Name	Relation	Percent
Beneficiary Name		/ % #2:		/	/ 0/
•	/	/ %0 #2:		/	/ %
Beneficiary Name #1:	/	/ % #2:		1	/ %
#1: -		/ % #Z:		,	/ %
#1: Employee Sig	gnature i insurance company and benefit plan selected, unders	standing all benefits and coverage as specified in			gulations therein specifie
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HealthPass Use Only: Accepted by