

# EMPLOYEE HEALTHCARE/LIFE ENROLLMENT FORM



GROUP NAME \_\_\_\_\_

GROUP NUMBER \_\_\_\_\_

**NOTE: UPON COMPLETION, THIS FORM REPLACES ANY AND ALL PREVIOUS ENROLLMENT FORMS**

<b>EMPLOYEE INFORMATION</b>	
EMPLOYEE NAME (LAST, FIRST, MIDDLE INITIAL)	DATE OF BIRTH      SOCIAL SECURITY NUMBER
STREET/MAILING ADDRESS	
CITY, STATE, ZIP	SEX      HOME PHONE NUMBER
MARITAL STATUS: <input type="checkbox"/> -SINGLE <input type="checkbox"/> -MARRIED <input type="checkbox"/> -DIVORCED <input type="checkbox"/> -WIDOWED	DATE OF FULL TIME EMPLOYMENT

COVERAGE REQUEST:    EMPLOYEE/SINGLE <input type="checkbox"/> -HEALTH <input type="checkbox"/> -LIFE (IF APPLICABLE) SPOUSE <input type="checkbox"/> -HEALTH <input type="checkbox"/> -LIFE (IF APPLICABLE) CHILDREN <input type="checkbox"/> -HEALTH <input type="checkbox"/> -LIFE (IF APPLICABLE)
I <u>DECLINE</u> MEDICAL COVERAGE FOR: <input type="checkbox"/> -MYSELF AND MY ELIGIBLE DEPENDENTS <input type="checkbox"/> -MY SPOUSE <input type="checkbox"/> -MY DEPENDENTS (COMPLETE BACK OF FORM)

<b>DEPENDENT INFORMATION:</b> PLEASE COMPLETE FOR ALL DEPENDENTS COVERED BY THIS REQUEST						DOES DEPENDENT HAVE OTHER COVERAGE? IF SO, LIST INSURANCE CO. NAME
DEPENDENT NAME (FIRST AND LAST)	SEX M/F	RELATIONSHIP TO EMPLOYEE	DATE OF BIRTH MO/DAY/YR	SOCIAL SECURITY #		
<b>SPOUSE</b>		<b>SPOUSE</b>				
1.						
2.						
3.						
(LIST ADDITIONAL CHILDREN ON AN ATTACHED SHEET.) ATTACH COPIES OF LEGAL COURT CUSTODY DECREES OR QUALIFIED MEDICAL CHILD SUPPORT ORDER						
ARE ANY DEPENDENTS AGE 19 AND OVER ATTENDING SCHOOL ON A FULL TIME BASIS? <input type="checkbox"/> -YES <input type="checkbox"/> -NO <b>(A LETTER FROM THE REGISTRAR CONFIRMING FULL TIME STUDENT STATUS MUST BE PROVIDED BEFORE COVERAGE BEGINS.)</b>						
DEPENDENT NAME/SCHOOL			DEPENDENT NAME/SCHOOL			

<b>SPOUSE INFORMATION:</b> COMPLETE ONLY IF REQUESTING COVERAGE FOR SPOUSE.		IS SPOUSE EMPLOYED?	<input type="checkbox"/> -YES <input type="checkbox"/> -NO
SPOUSE'S EMPLOYER (COMPANY NAME)	EMPLOYER ADDRESS (CITY, STATE, ZIP)		
DOES YOUR SPOUSE HAVE GROUP MEDICAL INSURANCE THROUGH HIS/HER EMPLOYER? <input type="checkbox"/> -YES <input type="checkbox"/> -NO IF YES, <input type="checkbox"/> -SINGLE <input type="checkbox"/> -FAMILY      EFFECTIVE DATE OF COVERAGE:			
IS ANY DEPENDENT OR SPOUSE DISABLED? <input type="checkbox"/> -YES <input type="checkbox"/> -NO (QUESTION ASKED FOR COORDINATION OF BENEFITS INFO ONLY)	DATE DISABILITY BEGAN	TYPE OF DISABILITY	

<b>LIFE INSURANCE BENEFICIARY DESIGNATION</b> LIST YOUR PRIMARY AND CONTINGENT (2 <sup>ND</sup> CHOICE) BENEFICIARIES HERE. IF YOU LIST MORE THAN ONE PRIMARY OR CONTINGENT BENEFICIARY, YOUR BENEFIT WILL BE DIVIDED EQUALLY AMONG THE SURVIVING BENEFICIARIES UNLESS YOU INDICATE OTHERWISE. YOU MAY CHANGE YOUR BENEFICIARY AT ANY TIME. (IF BENEFICIARY IS A TRUST, GIVE COMPLETE NAME OF TRUST AND TRUSTEE.)	
PRIMARY BENEFICIARY NAME(S) AND RELATIONSHIP TO YOU	CONTINGENT BENEFICIARY NAME(S) AND RELATIONSHIP TO YOU

## IMPORTANT NOTICE

**PLEASE CAREFULLY REVIEW AND SIGN THE REVERSE SIDE.  
YOUR SIGNATURE IS REQUIRED BEFORE THIS FORM CAN BE PROCESSED !!**



### - - - EMPLOYER USE ONLY - PLEASE COMPLETE - - -

<input type="checkbox"/> -NEW EMPLOYEE <b>CHANGE:</b> (CHECK ONE) <input type="checkbox"/> -SPECIAL ENROLLEE <input type="checkbox"/> -LATE APPLICANT <input type="checkbox"/> -COBRA <input type="checkbox"/> -RETIREE <input type="checkbox"/> -OTHER ➤ <b>PLEASE EXPLAIN CHANGE AND DATE OF "QUALIFYING" EVENT AND EMPLOYEE/DEPENDENT NAMES, IF APPLICABLE:</b>					
COVERAGE REQUESTED:    EMPLOYEE/SINGLE <input type="checkbox"/> -HEALTH <input type="checkbox"/> -LIFE <input type="checkbox"/> -DECLINE MEDICAL COVERAGE SPOUSE <input type="checkbox"/> -HEALTH <input type="checkbox"/> -LIFE <input type="checkbox"/> -DECLINE MEDICAL COVERAGE CHILDREN <input type="checkbox"/> -HEALTH <input type="checkbox"/> -LIFE <input type="checkbox"/> -DECLINE MEDICAL COVERAGE					
HIRE DATE	ELIGIBILITY DATE	ORIGINAL EFFECTIVE DATE OF MEDICAL COVERAGE	EFFECTIVE DATE OF CHANGE	<b>EMPLOYER AUTHORIZED SIGNATURE</b>	
<b>PRIOR CREDITABLE COVERAGE REQUEST:</b>					
<input type="checkbox"/> -CERTIFICATE ATTACHED	<input type="checkbox"/> -CERTIFICATE TO FOLLOW	<input type="checkbox"/> -NO PRIOR CREDITABLE COVERAGE (NO CERTIFICATE)			

# THE HEALTH POOL OF SOUTH DAKOTA

**IMPORTANT INFORMATION: PLEASE READ AND SIGN BELOW**

## HEALTHCARE DECLINATION AND PRE-EXISTING CONDITION INFORMATION

### 1. PRE-EXISTING CONDITION LIMITATION (PLEASE READ YOUR HEALTHCARE PLAN BOOK FOR COMPLETE REQUIREMENTS)

IN THE EVENT THAT THE PARTICIPANT OR DEPENDENT COVERED UNDER THIS PLAN RECEIVED MEDICAL ADVICE, DIAGNOSIS, TREATMENT, CARE OR HAD TAKEN OR PURCHASED PRESCRIBED DRUGS IN THE 6 MONTHS PRIOR TO HIS ELIGIBILITY DATE (DEFINED AS THE EARLIER OF THE FIRST DAY OF COVERAGE IN THE PLAN OR THE FIRST DAY OF THE WAITING PERIOD FOR SUCH ENROLLMENT IN THE PLAN), COVERAGE FOR THE CONDITION THAT WAS TREATED SHALL BEGIN AFTER A PERIOD OF 6 CONSECUTIVE MONTHS AFTER THE ELIGIBILITY DATE, (12 MONTHS FOR LATE APPLICANTS) WITH OR WITHOUT MEDICAL TREATMENT FOR THE PRE-EXISTING CONDITION. LATE APPLICANTS (NO QUALIFYING EVENT) WILL BE DENIED ENROLLMENT UNTIL THE NEXT OPEN ENROLLMENT DATE.

THE EXCLUSION OF COVERAGE DUE TO THE ABOVE PRE-EXISTING PROVISION OF THIS PLAN MAY BE REDUCED OR ELIMINATED FOR THOSE PERSONS THAT WERE PREVIOUSLY COVERED BY "CREDITABLE COVERAGE", IF COVERAGE UNDER THIS PLAN BEGINS WITHIN 63 DAYS AFTER DISCONTINUANCE OF COVERAGE UNDER THE OTHER PLAN (NOT INCLUDING ANY WAITING PERIOD). ANY PORTION OF A PRE-EXISTING LIMITATION SATISFIED BY THE PREVIOUS PLAN WILL BE RECOGNIZED BY THIS PLAN.

YOU HAVE THE RIGHT TO DEMONSTRATE CREDITABLE COVERAGE (AND ANY APPLICABLE WAITING PERIODS), BY PRESENTING A CERTIFICATE OF COVERAGE FROM YOUR PREVIOUS GROUP HEALTH OR INDIVIDUAL HEALTH PLANS. THE PARTICIPANT AND/OR DEPENDENT(S) HAVE THE RIGHT TO REQUEST A CERTIFICATE OF COVERAGE FROM A PRIOR PLAN OR ISSUER AND IF NECESSARY, THIS PLAN WILL ASSIST IN OBTAINING A CERTIFICATE FROM A PRIOR PLAN OR ISSUER. **NOTE: CREDITABLE COVERAGE WILL NOT APPLY IF THERE HAS BEEN A GAP IN COVERAGE OF MORE THAN 63 DAYS.**

-YES **DID YOU OR ANY OF YOUR DEPENDENTS HAVE GROUP OR INDIVIDUAL MEDICAL COVERAGE WITHIN THE 12 MONTHS PRIOR TO THE EFFECTIVE DATE OF THIS PLAN?**  
 -NO  
**(IF YES, PLEASE ATTACH YOUR CERTIFICATE OF PRIOR CREDITABLE HEALTH COVERAGE.)**

### 2. SPECIAL ENROLLMENT PERIOD

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 31 DAYS AFTER YOU LOSE YOUR OTHER COVERAGE.

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 31 DAYS AFTER THE MARRIAGE, BIRTH, ADOPTION OR PLACEMENT FOR ADOPTION. DETAILS OF SPECIAL ENROLLMENT PROVISIONS CAN BE REVIEWED IN THE EMPLOYEE BENEFIT PLAN BOOK.

**IMPORTANT: THIS FORM MUST BE COMPLETED AND ON FILE WITH YOUR EMPLOYER OR THE SPECIAL ENROLLMENT PERIOD DESCRIBED ABOVE WILL NOT APPLY.**

### 3. DECLINATION OF COVERAGE

I HAVE BEEN GIVEN THE OPPORTUNITY TO PARTICIPATE IN THE GROUP HEALTHCARE PLAN OFFERED BY MY EMPLOYER, AND I DECLINE PARTICIPATION FOR:

MYSELF AND MY ELIGIBLE DEPENDENTS: NAMES: \_\_\_\_\_

MY ELIGIBLE DEPENDENTS: NAMES: \_\_\_\_\_

REASON FOR DECLINING COVERAGE (CHECK ONE):

- CURRENTLY COVERED UNDER ANOTHER MEDICAL BENEFIT PLAN  
 OTHER

## ASSIGNMENT AND AUTHORIZATION

**ASSIGNMENT:** I HEREBY AUTHORIZE PAYMENTS DIRECTLY TO THE PROVIDER OF SERVICE BY MY EMPLOYER'S HEALTHCARE PLAN HEREIN NAMED OF THE GROUP BENEFIT'S PAYABLE TO ME. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY THIS ASSIGNMENT.

**AUTHORIZATION:** I HEREBY AUTHORIZE RELEASE, TO OR BY FIRST ADMINISTRATORS, INC., OF ANY HOSPITAL, MEDICAL, OR OTHER INSURANCE INFORMATION CONCERNING MYSELF OR ANY OF MY DEPENDENTS WHICH MAY BE REQUIRED TO PROCESS MY CLAIM. A PHOTOCOPY OF THIS AUTHORIZATION MAY BE HONORED. I HEREBY REQUEST THE AMOUNT(S) AND FORMS FOR COVERAGE FOR WHICH I AM OR MAY BECOME ELIGIBLE, AND HEREBY AUTHORIZE MY EMPLOYER TO DEDUCT THE REQUIRED CONTRIBUTION, IF ANY, FROM MY EARNINGS.

**I HAVE READ AND COMPLETED ALL OF THE INFORMATION OUTLINED ABOVE**

\_\_\_\_\_  
EMPLOYEE SIGNATURE

\_\_\_\_\_  
DATE SIGNED

# THE HEALTHPOOL OF SOUTH DAKOTA

## ENROLLMENT CHANGE REPORT

GROUP NAME: \_\_\_\_\_

PLAN #: HP

MONTH \_\_\_\_\_

<i>Social Security #</i> ----- Name	Effective Date	Add	Term	Coverage Change		Reinstatement Date for COBRA	Comments or Explanation of Change
				From	To		
-----							
-----							
-----							
-----							
-----							
-----							
-----							
-----							

**Note: An updated enrollment form is required for all changes and additions. Attach Healthcare Enrollment Form when applicable.**

Complete and mail by 1st of each month to:

FIRST ADMINISTRATORS, ENROLLMENT DEPARTMENT, P.O. BOX 5091, SIOUX FALLS, SD 57117.

AUTHORIZED SIGNATURE	DATE

## ENROLLMENT CHANGE REPORT HELP SHEET

GROUP NAME: \_\_\_\_\_(1)\_\_\_\_\_ PLAN #: \_\_\_\_ (2) \_\_\_\_\_ MONTH \_\_\_\_\_(3)\_\_\_\_\_

Social Security # -----	Effective Date	Add	Term	Coverage Change		Reinstatement Date for COBRA	Comments or Explanation of Change
Name				From	To		
(4) -----	(6)	(7)	(8)	(9)	(9)	(10)	(11)
(5)							

- (1) **Group Name:** Enter name of group [City of New York]
- (2) **Plan Number:** Will be completed by First Administrators.
- (3) **Month:** Enter month of change [January 2002].
- (4) **Social Security number:** Enter employee social security number.
- (5) **Name:** Enter name of person who the change is for.
- (6) **Effective Date:** of the change for an “Add”, “Term”, “Change”, “Reinstatement of COBRA”.
- (7) **Add:** Check this box if you are adding coverage for an employee. If the “add” is for someone other than the employee, use the comment section for an explanation. For example, if the change is an “add”, the effective date of coverage is required. Use the Schedule of Benefits explanation for “Effective date of coverage and waiting period”. This will either be the date of hire, first of the month following date of hire, etc.
- (8) **Term:** Check this box for a termination of coverage. If the effective date is for a termination, use the effective date of the termination according to the Schedule of Benefits in your plan book. For example, this may be the date of termination or the end of the month.
- (9) **From/To:** This will be the change of status. For example, you may be changing coverage from single to family or family to single coverage. Use the comment section for further explanation.
- (10) **Reinstatement Date for COBRA:** The date to reinstate COBRA should be the date you initially terminated coverage. When you have a termination of employment, reduction in hours, death, divorce, or cessation of dependent status, you need to initially *terminate* coverage. The beneficiary has 60 days to elect COBRA. In the meantime, they are terminated. When and if they elect coverage (within the 60 days), you will then reinstate the coverage. This provision protects your plan from paying two months (60 days) of claims before the beneficiary actually declines the COBRA coverage.
- (11) **Comments or Explanation of Change:** Use this section to further explain any changes in coverage. This assists the Enrollment Department to ask the right questions if the request for change is unclear.
- (12) **Signature:** Remember to sign the bottom!!

If you have any questions, please call the First Administrators Enrollment Department at 605-334-7240.

## **ENROLLMENT FORM HELP SHEET**

### **COVERAGE REQUEST, CLASSIFICATION, AND/OR ELIGIBILITY**

(Bottom section of Enrollment Form, front page)

**(TO BE COMPLETED AND VERIFIED BY EMPLOYER)**

This Section should be a verification of coverage election, classification, changes, eligibility and coverage dates. Review and complete those items which pertain to your business, as listed on your Healthcare Enrollment form.

- ◆ New Employee: at the time of initial eligibility.
- ◆ Special Enrollee: if adding coverage for employee and/or dependent due to: (1) involuntary loss of coverage because of termination of employment, death, divorce, cessation of dependent status, (2) newborn birth or adoption, (3) marriage.
- ◆ Late Enrollment: if over 31 days have passed since the employee was first *eligible* for coverage. This may be the beginning of a "waiting period" as outlined in your healthcare plan book.
- ◆ COBRA: if change in coverage is due to COBRA election (within 60 days) of; termination of employment, reduction in hours, death, divorce or cessation of dependent status.
- ◆ Other: please describe other circumstances for example, change is a name change due to marriage or divorce, or address change or updated other information.
- ◆ Explanation: Use this area to explain the special enrollee information: adding newborn who was born on MMDDYY, adding spouse due to marriage on MMDDYY, etc.
  
- ◆ Medical Coverage Request: Confirm Employee/Single, Spouse or Children for Medical coverage or Decline Medical Coverage Election.
- ◆ Life Coverage Request: Confirm Employee/Single, Spouse or Children (where life coverage is applicable to group)
  
- ◆ Hire Date: This section is for the original date of hire by the current employer. This date should be the most recent date of hire.
- ◆ Eligibility Date: This section is generally the same as the date of hire unless not eligible for health coverage i.e., part-time or less than the required number of hours to be eligible for health coverage.
- ◆ Original Effective Date of Coverage: This section is the date of eligibility, for example, first of the month following date of hire, etc.
- ◆ Effective Date of Change: This section is for any changes after the employee is first covered. For example, if the change is to add dependents or a newborn, marriage or change in classification, the effective date of the change should be entered here. The explanation of the change should be entered in the Explanation section above
  
- ◆ Prior Creditable Coverage: This box should be checked if the employee is a new hire (newly eligible) and had prior creditable coverage. ***This question should be asked of the employee and explained to them.***
- ◆ Certificate to Follow: This box should be checked after explanation to the employee and a Certificate has been requested from their former employer. Please indicate if Indian Health Service or CHAMPUS was the prior carrier.
- ◆ No Prior Creditable Coverage: Check this box if the employee explains that he or she has not had any prior coverage in the last 12 months.
- ◆ Employer Authorized Signature: ***Must be signed*** for verification of the above information!!!!

