

IMPORTANT: ALL FIELDS ON THIS FORM MUST BE COMPLETED FOR TIMELY PROCESSING.

# ENROLLMENT/CHANGE FORM

## A EMPLOYEE INFORMATION (To Be Completed By Employee)

I ELECT THE FOLLOWING PLAN FOR MYSELF AND MY DEPENDENTS:  PPO/HealthAssurance  Coordinated Care PPO/HealthAssurance (POS)  HealthAssurance Flex

LAST NAME	FIRST NAME	MI	M/F	BIRTH DATE	SOCIAL SECURITY NO.	COVERAGE TYPE	MARITAL STATUS
ADDRESS	E-MAIL ADDRESS	PRIMARY CARE PHYSICIAN # - PCP ID <i>If enrolling in Coordinated Care PPO</i>		BUSINESS PHONE	DATE OF HIRE	<input type="checkbox"/> SINGLE <input type="checkbox"/> PARENT/CHILD <input type="checkbox"/> FAMILY <input type="checkbox"/> HUSBAND/WIFE	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED (date) <input type="checkbox"/> DIVORCED (date) <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED
CITY	STATE	ZIP CODE	COUNTY	HOME PHONE	<input type="checkbox"/> ACTIVE <input type="checkbox"/> RETIRED		

## B FAMILY MEMBERS TO BE COVERED OR DELETED

ENROLL OR DELETE	FULL NAME (LAST, FIRST, MI)	SEX	RELATIONSHIP	BIRTH DATE	STUDENT OR DISABLED	SOCIAL SECURITY NO.	PRIMARY CARE PHYSICIAN	SITE CODE/PCP ID
E	D 01	M / F	Spouse	/ /				
E	D 02	M / F		/ /	S / D			
E	D 03	M / F		/ /	S / D			
E	D 04	M / F		/ /	S / D			
E	D 05	M / F		/ /	S / D			
E	D 06	M / F		/ /	S / D			

## C OTHER INSURANCE

Do you or your dependents have other coverage? No  If Yes complete the following:

List all family members with Medical Health Insurance in addition to HealthAssurance coverage.

POLICY HOLDER	BIRTH DATE	EMPLOYER	INSURANCE COMPANY
LIST DEPENDENTS COVERED			

Do you or your dependents have Medicare Coverage? Yes  No  If Yes, please complete the following:

NAME	MEDICARE ID NO.	PART A EFF. DATE	PART B EFF. DATE
NAME	MEDICARE ID NO.	PART A EFF. DATE	PART B EFF. DATE

## D CONDITIONS OF ENROLLMENT

I REPRESENT THAT ALL INFORMATION SUPPLIED ON THIS FORM IS TRUE AND COMPLETE. I HEREBY AGREE TO THE CONDITIONS OF ENROLLMENT ON THE REVERSE SIDE OF THIS APPLICATION.

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_ 20\_\_

## E EMPLOYER INFORMATION (To Be Completed By Employer)

GROUP NO.	GROUP NAME	EFFECTIVE DATE	EMPLOYER'S SIGNATURE	DATE
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### ENROLL

OPEN ENROLLMENT  REINSTATE (reason: \_\_\_\_\_)  
 NEW HIRE (date of hire: \_\_\_\_\_)  COBRA (qualifying event: \_\_\_\_\_)  ADDRESS CHANGE  
 OTHER (\_\_\_\_\_)  
 DIRECT PAY

### CHANGE

ADD DEPENDENT (reason for addition: \_\_\_\_\_)  
 DELETE DEPENDENT (reason for deletion: \_\_\_\_\_)  
 CANCEL COVERAGE (reason: \_\_\_\_\_)  
 NAME CHANGE  
 PREVIOUS NAME \_\_\_\_\_  
 DATE RECEIVED \_\_\_\_\_  
 (TO BE COMPLETED BY HEALTHASSURANCE)

PLEASE ATTACH VERIFYING DOCUMENTATION WHEN ADDING DEPENDENTS.

SEE REVERSE SIDE FOR CONDITIONS OF ENROLLMENT.

WHITE-HealthAssurance, PINK-Company, BLUE-Member (Please keep this as your termination ID until you receive your ID cards)

## CONDITIONS OF ENROLLMENT

1. **I hereby enroll for benefits for the person(s) listed, and agree that I and my family members shall abide by the provisions of coverage in the applicable Group Contract under which we are enrolled and any related documents.**
2. **I understand** that any material misrepresentation or fraud in answering the questions on this application or nonpayment of premium, coinsurance, deductible, or copayment may result in termination of coverage. All benefits and exclusions are set forth in the applicable Group Contract and related documents. I understand that the effective date of coverage shall be determined by my employer according to the guidelines established between my employer and HealthAssurance.
3. **I authorize** any physician, hospital, or other health care provider and persons to disclose to HealthAmerica or HealthAssurance any medical information of individuals set forth on this application for the purposes of utilization review, quality review, peer review, and other plan administration and payment functions of HealthAmerica and HealthAssurance. I understand that personal information relating to the individuals specified on this application is considered confidential by HealthAmerica and HealthAssurance and is not shared with third parties except for regulatory reporting and other purposes permitted under applicable federal and state law, including functions necessary to administer my benefits.
4. **I agree** to assign benefits to participating providers.
5. **I authorize** deductions from my earnings of the required contribution, if any, toward the cost of the coverage (if applicable).
6. **I understand** that it is my responsibility to report to my employer, in a timely manner, any changes in the eligibility of the individuals listed or any change to the information I have provided on this Enrollment Form.
7. **I understand** that I can only change health coverage during the time period my employer and HealthAmerica and HealthAssurance specify, unless I qualify as a special enrollee.
8. Fully insured HealthAssurance PPO and Coordinated Care PPO plans are underwritten by HealthAssurance Pennsylvania, Inc.
9. The HealthAssurance PPO and HealthAssurance Coordinated Care PPO, a gate-keeper PPO, (sometimes referred to as a Point-of-Service plan) are separate and distinct health care products regulated by the Pennsylvania Departments of Health and Insurance.
10. **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 subjects such person to criminal and civil penalties.**
11. **This managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered. For questions, call 1-800-788-8445 in central and eastern Pennsylvania, 1-800-752-4165 in northwestern Pennsylvania, or 1-800-735-4404 in western Pennsylvania and Ohio.**

