HealthComp

GROUP ENROLLMENT/CHANGE FORM

P.O. BOX 45018 FRESNO CA 93718-5018
(800) 442-7247 FAX (559) 499-2464

☐ New Enrollment ☐ Annual Enrollment
☐ Name/Address Change ☐ Change Enrollment
☐ Reinstatement ☐ Decline Coverage
☐ Rehire ☐ Termination

(Shaded area for office use only

PART 1 EMPLOYEE INFORMATION

EMPLOYER			**PLAN CHOICE** ☐EPO ☐PPO ☐STANDARD ☐OTHER		**GROUP NUMBER**	**Benefit Type(s):** ☐Medical ☐Dental ☐Vision ☐Rx ☐Life	
EMPLOYEE	**LAST**	**FIRST**	**MI**	**SS #**		**EFFECTIVE DATE**	
						MED	**DEN** / **VIS**
ADDRESS	**STREET**	**CITY**	**STATE**	**ZIP CODE**	**HOME PHONE** ( )	**BIRTHDATE**	**MO** **DAY** **YEAR**
HIRE DATE	**JOB TITLE OR RETIRED**	**SALARY** ☐HRLY ☐MNLY ☐YRLY	**LIFE AMT. $**	☐MALE ☐FEMALE	☐SINGLE ☐MARRIED ☐WIDOWED ☐DIVORCED ☐SEPARATED	**DEPARTMENT**	
BENEFICIARY	**RELATIONSHIP**	**SS #**	Primary Care Physician (EPO Plan only)	Physician Phone Number and Address			
EMPLOYEE TERMINATION DATE	**REASON**				**ID CARD FORMAT**	**MASK**	

PART 2 DEPENDENT INFORMATION

DEPENDENT INFORMATION (List persons to be covered/terminated.): [1] **Relationship Code (relationship to participant)** **SPO=**Spouse **SON=**Son **DAU=**Daughter **DEP=**Other Dependent — [2] **Benefit Type(s): M=**Medical **D=**Dental **V=**Vision **Rx=**Prescription

Add/ Drop	Last Name	First Name	MI	Social Security Number	Birth Date	Gender	1 Rel. Code	2. Benefits	Full Time Student	Disabled	Primary Care Physician (EPO Plan Only) Name	Address & Phone #
Select						Select		Select		Select		
Select						Select		Select		Select		
Select						Select		Select		Select		
Select						Select		Select		Select		
Select						Select		Select		Select		

IF ADDING OR DROPPING DEPENDANT STATE REASON:

PART 3 OTHER INSURANCE INFORMATION

ARE YOU OR ANY OF YOUR DEPENDENTS (INCLUDING SPOUSE) COVERED UNDER ANOTHER HEALTH PLAN OR MEDICARE? ☐**YES** ☐**NO** **IF YES, PLEASE COMPLETE THIS SECTION.** **Check if additional form attached.** ☐

Name of other policy holder	Birth Date	Social Security Number	[3] Rel. Code	Sponsoring Employer	Insurance Carrier or Medicare	Group Number	[4] Benefit Types	[5] Policy Types	Coverage Date(s)
									Begin End

PERSONS COVERED UNDER ABOVE POLICY:

3 **Relationship Code** (specify relation to participant): SPO=Spouse OTH=Other | 4 **Benefit Type(s)**: **M**=Medical **D**=Dental **V**=Vision **Rx**=Prescription | 5 **Policy Type**(s): **IND**=Individual Policy **GRP**=Group Plan **HMO**=Health Maintenance Organization **MED**=Medicare

PART 4 COVERAGE DECLINATION

To be completed if any coverage is declined or refused by an eligible employee and / or their eligible family members;

HEALTH PLAN COVERAGE (CHECK IF DECLINED)

I decline coverage for:

☐ Myself ☐ Children
☐ Spouse ☐ Spouse and Children

REASON FOR DECLINING HEALTH COVERAGE (CHECK IF DECLINED)

☐ Covered by spouse's group coverage
☐ Spouse covered by employer's group medical coverage
☐ Medicare
☐ Other (explain) _____

I acknowledge that the available coverages have been explained to me by my employer, and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any, and understand that evidence of insurability may be required should I choose to apply for coverage at a later date. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage.

_____ _____
If declining coverage for employee/dependent(s) please sign here. Date

PART 5 DECLARATION

☐ I hereby request the amount of coverage for which I may become eligible under the group employee benefits plan of my employer and authorized payroll deductions from my earnings (if any) required to cover my share of the premium. I confirm the above beneficiary information.

_____ _____
Employee's Signature Date