Member Enrollment/Change Form

Medical

Employer Name: _____ **Group Number:** _____

Submit your completed form and supporting documentation to your Human Resources Department.

Employer: Complete Prior to Submitting to HPI

☐ Active ☐ COBRA Department/Division/Location (if applicable):

☐ New Employee ☐ Open Enrollment ☐ Terminate from Plan

☐ Remove Dependent(s) Only ☐ Add Dependent Coverage ☐ Change of Status

Effective Date:	Hire Date:	Change Effective Date:	Termination Date:

Reason for change:

Employee Information

Last Name:	*First Name:*	*MI:*	*SS#:*	*Date of Birth:*

Mailing Address:	*City:*	*ST:*	*ZIP Code:*

Gender:	*Marital Status:*	*Email Address:*	*Phone:*

Coverage Election

☐ **Medical Plan Option** ***(if applicable):***

☐ Employee Only

☐ Employee + Spouse/Partner ☐ Employee + Ex Spouse ☐ Employee + Family ☐ Employee + Child(ren)

Add or Drop Dependents

	Last Name	*First Name*	*MI*	*Gender*	*Date of Birth*	*Relationship to Employee*	*Dependent SS Number (REQUIRED)*	*Add/Drop*
1.							- -	
2.							- -	
3.							- -	
4.							- -	

Are you or any of your dependents covered by another medical plan? ☐ Yes ☐ No *If yes, select who:* ☐ Self ☐ Spouse ☐ Child(ren) ☐ Ex-Spouse

(if YES): Medical Policy# and Insurance Co.: _____ *Policyholder's Name:* _____

Address of Policyholder's Employer: _____

☐ **YES: Electing Coverage**

By signing below, I am attesting that I wish to elect coverage under my employer's benefit plan for the coverage indicated above. I understand that my enrollment will be subject to the terms of the Plan. I authorize any required deductions from my earnings. I authorize the release of medical records to Health Plans, Inc. or its representatives; a photocopy shall be as valid as the original. I certify that the above information is accurate and complete and I am actively working the minimum number of hours required for coverage. I may not revoke my election unless I have a "qualifying event," such as a change in my legal marriage status, employment status or change in the number of my dependents.
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Employee Signature: _____

☐ **NO: Waiving Coverage**

If you are declining enrollment in the Plan for yourself and/or your dependents (including your spouse) because you and/or your dependents are covered under other health insurance coverage, you may be able to enroll yourself or your dependents in this Plan in the future, provided that you request enrollment within 30 days after your other coverage ends. 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 30 days after the marriage, birth, adoption or placement for adoption.

Employee Signature: _____

Clear Form