THE HEALTH PLAN/THP – ENROLLMENT SERVICES DEPARTMENT – ENROLLMENT CHANGE FORM (Revised 03/11)

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Employee ID #:	**Group Name:**	**Group #:**	**Division # (if applicable):**

Add Employee – Enrollment Form Required

Employee Name:		**Date of Event:**	**Effective Date:**
__New Hire __Name Change __Rehire __Recall	__Open Enrollment __Part time to full time __Other; please explain	__HIPAA Qualified Event – Special Enrollment * __Section 125 Qualified Event * * LOSS OF COVERAGE REQUIRES CERTIFICATE OF COVERAGE FROM PREVIOUS CARRIER.	

FEDERAL COBRA: ATTACH A COPY OF THE SIGNED COBRA ELECTION FORM /Enrollment Form Required if Family Status Change

___ **Federal COBRA Event Date:** ___ **State Continuation (Mini-COBRA) Event Date:**	**COBRA Effective Date:**	**COBRA End Date:**

Add Dependent(s)

	Date of Event:	**Effective Date:**

Name(s) Last, First, Middle	Date of Birth	M / F	Relationship	PCP	SS#

__New Spouse __Open Enrollment __Elected Cobra __Other; please explain	__Newborn __Adoption ** __Qualified Child Support Order ** ** Legal Doc. Required	__HIPAA Qualified Event – Special Enrollment * __Section 125 Qualified Event * * LOSS OF COVERAGE REQUIRES CERTIFICATE OF COVERAGE FROM PREVIOUS CARRIER.

Terminate Employee

Name:		**Date of Event:**	**Effective Date:**
__Term Employment (Voluntary) __Term Employment (Involuntary) __Termed COBRA __Open Enrollment	__Deceased __Personal __Retired __Layoff __Coverage Through Spouse __Transfer to HP Medicare Option	__Moved Out of HP Service Area __Transfer from Group/Division to New Group/Division #_____ __Exhausted FMLA, Sick Leave or Workers' Comp __Other; please explain	

Terminate Dependent(s)

Name(s):		**Date of Event:**	**Effective Date:**
__Dependent Deceased __Divorce __Medicare Eligible	__No Longer Student __Dependent Married __Over Age Limit	__Open Enrollment Drop __Dependent moved out of HP Service Area __Other, please explain	

Address/Telephone Number Change:

Signature (Group Representative): _____ ***Date Submitted:*** _____

SUBSCRIBER/EMPLOYEE

To be eligible to enroll as a subscriber, the employee must reside in the HP/THP's enrollment area and a full-time employee of the Group (as defined by the employer group and agreed to by the HP/THP). The person must also be entitled to participate in the hospital and medical benefits arranged by the Group, or entitled to coverage under COBRA.

DEPENDENTS

SPOUSE: The employee's legally married spouse may be included on the coverage. To be eligible to enroll as a dependent spouse, the person must live in the HP/THP's Enrollment Area, and an enrollment change form must be completed and received at the HP/THP within 31 days from the date of marriage. If the spouse has a different last name from the employee, legal documentation (i.e., a copy of the marriage certificate) is required to confirm the marital relationship. **Coverage will not be activated unless documentation is attached to the enrollment form.**

A divorced or common law spouse is excluded from eligibility (legally separated/separate maintenance if required by Group). Coverage will end for a divorced spouse on the divorce date (unless specified differently by the employer and agreed to by the HP/THP).

Dependent Children must meet the definition of a "qualifying child" as stated in IRS Publication 501, section 152.

Important note: When children are added with last names different than the subscriber, legal documentation is required to confirm the parental relationship to the subscriber or to the subscriber's legally married spouse (i.e., birth certificates, copies from divorce papers showing the non-custodial parent's responsibility to provide health coverage, court documentation showing proof of paternity). **Coverage will not be activated unless documentation is attached to the enrollment form.**

Newborn children are covered from the moment of birth and remain effective for a 31- day period. To continue coverage beyond the 31-day period, the subscriber must submit an enrollment change form through the employer within 31 days from the date of birth.

A Handicapped Child is a qualified dependent child as stated in the IRS Publication 501, Section 152 that is permanently and totally disabled if both of the following apply.

- He or she cannot engage in any substantial gainful activity because of a physical or mental condition.
- A doctor determines the condition has lasted or can be expected to last continuously for at least a year or can lead to death.

Proof of such incapability and dependency is required.

Federal COBRA

Please write the Cobra event, beginning and end dates on the Enrollment Change Form. If the family status changes from the active to Cobra coverage, a new enrollment form must be completed. AS A REMINDER, YOU **MUST ATTACH A COPY OF THE SIGNED COBRA ELECTION FORM** TO THE CHANGE FORM. **Coverage will not be activated unless a copy of the signed election form is attached.**

State Continuation (Mini-COBRA/less than 20 employees)

Please write the Cobra event, beginning and end dates on the Enrollment Change Form. If the family status changes from the active to Cobra coverage, a new enrollment form must be completed

INSURANCE FRAUD WARNING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements is guilty of insurance fraud.