ENROLLMENT FORM
(SEE INSTRUCTIONS ON BACK)

THP Insurance Company

1110 Main Street
Wheeling, WV 26003
P: 1.800.624.6961

EMPLOYER USE ONLY

GROUP NO. ☐☐☐☐☐☐☐☐☐☐ - ☐☐

EFFECTIVE DATE ☐☐☐☐☐☐☐☐

THP USE ONLY ☐ ☐☐☐☐☐☐ COV. PAYROLL

PLEASE PRINT

Employer Name

Employee Name (Last, First, M.I.)

Street Address Apt.#

City State County ZIP Code

Phone 1# Phone 2#

Email Address*

Employee Status: *(if changing enrollment status, skip to B)*

A: Date of Hire:_____ ☐Hourly or ☐Salary

☐ Active ☐ Retired ☐ COBRA ☐ Other, please explain:

Reason for Enrolling:

☐ New Group ☐ New Hire ☐ Other, please explain:

B: Reason for Change in Enrollment Status:

Must Complete an Enrollment Change Form.
(See Employer)

If you have any questions regarding eligibility for coverage, please contact your employer.

FAMILY MEMBERS TO BE ENROLLED

FAMILY CODE	LAST NAME	FIRST	MI	DATE OF BIRTH MO/DAY/YR	M OR F	SOCIAL SECURITY NUMBER *
EMP	Employee					
SP	Spouse					
03	Dependent					
04	Dependent					
05	Dependent					
06	Dependent					
07	Dependent					

**This information is used for internal purposes only.*

Have you ever been enrolled with THP before? ☐ YES ☐NO

Employee or spouse's maiden name: _____

If any dependents listed to enroll have last names that differ from the employee's, ***legal documentation must be attached to prove the relationship***. Examples: marriage certificate, adoption, guardianship or foster child papers.

Does spouse and all dependents listed above reside with the employee? ☐ YES ☐NO

If no, list spouse or dependent(s) and his/her address below:

NAME:_____ ADDRESS:_____

NAME:_____ ADDRESS:_____

Explanation for not residing with employee:_____

LANGUAGE

FAMILY CODE	
EMP	If available, which language do you prefer for written materials? _____ Can one or more members of your household read English? ☐ Yes ☐ No What language do you feel most comfortable speaking? ☐ English ☐ Other What is the primary language spoken at home? ☐ English ☐ Other If other, what language is preferred? _____
SP	If available, which language do you prefer for written materials? _____ Can one or more members of your household read English? ☐ Yes ☐ No What language do you feel most comfortable speaking? ☐ English ☐ Other What is the primary language spoken at home? ☐ English ☐ Other If other, what language is preferred? _____
03	If available, which language do you prefer for written materials? _____ Can one or more members of your household read English? ☐ Yes ☐ No What language do you feel most comfortable speaking? ☐ English ☐ Other What is the primary language spoken at home? ☐ English ☐ Other If other, what language is preferred? _____
04	If available, which language do you prefer for written materials? _____ Can one or more members of your household read English? ☐ Yes ☐ No What language do you feel most comfortable speaking? ☐ English ☐ Other What is the primary language spoken at home? ☐ English ☐ Other If other, what language is preferred? _____
05	If available, which language do you prefer for written materials? _____ Can one or more members of your household read English? ☐ Yes ☐ No What language do you feel most comfortable speaking? ☐ English ☐ Other What is the primary language spoken at home? ☐ English ☐ Other If other, what language is preferred? _____
06	If available, which language do you prefer for written materials? _____ Can one or more members of your household read English? ☐ Yes ☐ No What language do you feel most comfortable speaking? ☐ English ☐ Other What is the primary language spoken at home? ☐ English ☐ Other If other, what language is preferred? _____
07	If available, which language do you prefer for written materials? _____ Can one or more members of your household read English? ☐ Yes ☐ No What language do you feel most comfortable speaking? ☐ English ☐ Other What is the primary language spoken at home? ☐ English ☐ Other If other, what language is preferred? _____

RACE/ETHNICITY - OPTIONAL

FAMILY CODE	(This information is designed for the purpose of data collection and will not be used for determining eligibility, rating or claim payment.)
EMP	☐ White -01 ☐ African American/Black -02 ☐ Hispanic/Latino -03 ☐ Asian -04 ☐ American Indian/Alaska Native-05 ☐ Native Hawaiian/Other Pacific Islander-06 ☐ Other-07
SP	☐ White -01 ☐ African American/Black -02 ☐ Hispanic/Latino -03 ☐ Asian -04 ☐ American Indian/Alaska Native-05 ☐ Native Hawaiian/Other Pacific Islander-06 ☐ Other-07
03	☐ White -01 ☐ African American/Black -02 ☐ Hispanic/Latino -03 ☐ Asian -04 ☐ American Indian/Alaska Native-05 ☐ Native Hawaiian/Other Pacific Islander-06 ☐ Other-07
04	☐ White -01 ☐ African American/Black -02 ☐ Hispanic/Latino -03 ☐ Asian -04 ☐ American Indian/Alaska Native-05 ☐ Native Hawaiian/Other Pacific Islander-06 ☐ Other-07
05	☐ White -01 ☐ African American/Black -02 ☐ Hispanic/Latino -03 ☐ Asian -04 ☐ American Indian/Alaska Native-05 ☐ Native Hawaiian/Other Pacific Islander-06 ☐ Other-07
06	☐ White -01 ☐ African American/Black -02 ☐ Hispanic/Latino -03 ☐ Asian -04 ☐ American Indian/Alaska Native-05 ☐ Native Hawaiian/Other Pacific Islander-06 ☐ Other-07
07	☐ White -01 ☐ African American/Black -02 ☐ Hispanic/Latino -03 ☐ Asian -04 ☐ American Indian/Alaska Native-05 ☐ Native Hawaiian/Other Pacific Islander-06 ☐ Other-07

MEDICARE INFORMATION

Upon your effective date with THP (or within 60-days of the effective date) will you, or any of your covered dependents, have Medicare coverage? ☐ YES ☐NO

If yes, please provide the information below:

Medicare Enrollee Name	Medicare I.D. #	Part A Effective Date	Part B Effective Date
1. _____	_____	_____	_____
2. _____	_____	_____	_____

Do you have Medicare Part D coverage? ☐ YES ☐NO If yes, effective date: 1. _____

2. _____

OTHER HEALTHCARE COVERAGE

Upon your effective date with THP will you, or any of your covered dependents, have other healthcare coverage? ☐ YES ☐NO

If yes, please provide information below:

Coverage Type: ☐ Group Policy ☐ Individual Policy ☐ Workers' Compensation ☐ Medicaid ☐ Other

Covered Benefits: *(check all that apply)* ☐ Hospital/Medical ☐ RX ☐ Vision ☐ Dental ☐ Other, please explain:

_____

Name of other coverage: _____ Phone #: _____

Policyholder name: _____ I.D. #: _____

If other family members are covered, please list names: _____

_____ _____

_____ _____

_____ _____

ELECTION OF COVERAGE UNDER THP

I hereby elect coverage for myself, and my covered dependents listed on this Enrollment Form, for benefits offered under The THP Group Medical and Hospital Service Agreement ("the Agreement") with my Employer. I understand my eligible dependents and I must meet the eligibility guidelines as agreed to by my Employer and THP in conjunction with any State or Federal laws to include but not limited to the Patient Protection Affordable Care Act ("PPACA"), Ohio House Bill 1 (Ohio residents only) and IRS Publication 501, Section 152. (If you have any questions regarding eligibility for coverage, contact your Employer.)

I agree on my behalf, and on behalf of my covered dependents, to be bound by the benefits, deductibles, copayments, coinsurance payments, exclusions, limitations and other terms of the Agreement or as amended. Furthermore, at any time upon request by THP, I agree to provide THP any legal or other documentation to verify eligibility (i.e., Marriage Certificate, Birth Certificate, Driver License, Voter Registration). I understand that failure to comply with the request may cause interruption of claims processing or possible termination of coverage.

I understand on my behalf, and on behalf of my covered dependents, that certain information may be disclosed to other entities. (This disclosure is further explained in THP Privacy Notice included in the enrollment packet, or upon request or on THP's website at **www.healthplan.org**.)

I understand on my behalf, and behalf of my covered dependents, that all information furnished by me here is true and complete to the best of my knowledge and shall be deemed representations and that coverage can be rescinded if I, or my covered dependents or a person seeking coverage on my behalf or covered dependents behalf, performs an act, practice or mission that constitutes fraud; or makes an intentional misrepresentation of material fact, as prohibited by the terms of the Agreement.

Cancellation Notice: Any person obligated for any part of a prepayment may cancel such agreement within 72 hours after he/she has signed an agreement or offered to enroll. Cancellation occurs when written notice of cancellation is given to THP either in person or by mail.

Insurance Fraud Warning: "Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submit an application or files a claim containing false or deceptive statements is guilty of insurance fraud."

Employee signature: _____ Date: _____

If you are electing to enroll, this form MUST be completed in its entirety, failure to do so will cause a delay in your enrollment. Please review for completeness.

IF YOU ARE WAIVING COVERAGE, PLEASE COMPLETE THE FOLLOWING WAIVER OF COVERAGE.

WAIVER OF COVERAGE

Complete this section only if you wish to decline coverage offered for you and/or family member(s).

I hereby decline coverage for: ☐ Myself ☐ Spouse ☐ Dependent Children

Reason for decline:

☐ Have not met employer's eligibility ☐ Other health coverage ☐ Spousal coverage ☐ Other, please explain:

_____

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 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 31 days after the marriage, birth, adoption or placement for adoption.

I hereby certify that I have been given the opportunity to participate in the group insurance plan provided by my employer. If I and/or any of my eligible dependents desire to apply for this insurance at a later date, I may be required to wait until my group's renewal or until a special enrollment occurs before coverage will be offered.

Employer name: _____ *(please print)*

Employee name: _____ *(please print)*

Employee signature: _____ Date: _____