COMMUNITY FIRST HEALTH PLANS

Employee Application/Enrollment Form

PLEASE PRINT USING BLACK OR BLUE INK. ATTACH SHEETS IF NECESSARY; SIGN AND DATE ALL ATTACHMENTS

SECTION 1: WELCOME

☐ HMO Product Selection: _____

☐ PPO Product Selection: _____

(Sponsored by Community First Group Hospital Service Corporation)

Please indicate if you are a: ☐ New Applicant ☐ Current Participant

Date of Hire _____ Hours Worked per Week _____

If a Current Participant, choose from the following:

☐ Address Change ☐ Change status from dependent to employee

☐ Add Dependents ☐ Delete Dependents

(date of marriage/birth _____) (date of event _____)

☐ COBRA/State Continuation: Reason Code_____ Start Date _____ End Date _____

Company Name			Group Number
Last Name	First Name	M.I.	Sex ☐Male ☐ Female
Address Apt. # City, State, Zip Code			County
Home Phone Number ( )	Email Address (If Applicable)		Language of Choice ☐English ☐Spanish

Date of Birth	Height	Weight	Social Security Number	Marital Status ☐ Single ☐Divorced ☐ Widowed ☐ Married ☐ Separated

SECTION 2: PLAN SELECTION (Availability dependent upon your employer's selection)

Medical Coverage ☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Family ☐ None (Complete Section 5)

SECTION 3: ELIGIBLE DEPENDENTS

Full Name	Sex M/F	Date of Birth Social Security #	Full Time Student Y/N	Height Weight	Primary Doctor*
Spouse		DOB: SSN:		H: W:	
Dependent**		DOB: SSN:		H: W:	
Dependent**		DOB: SSN:		H: W:	
Dependent**		DOB: SSN:		H: W:	
Dependent**		DOB: SSN:		H: W:	

* For HMO Selection Only

** IMPORTANT: For court ordered dependent(s), legal documentation must be attached. If dependent does not reside with eligible employee, please provide address on a separate sheet.

SECTION 4: APPLICATION/ENROLLMENT QUESTIONS

1. Do you or any dependent(s) currently have any physical and/or communication disabilities? ☐ YES ☐ NO

2. Are you or any of your dependents eligible for Medicare benefits? ☐ YES ☐ NO
   If yes, complete Section 5.

3. Do you or any dependents currently have Medical coverage in addition to this plan? ☐ YES ☐ NO
   If yes, complete Section 5.

SECTION 5: OTHER MEDICAL COVERAGE INFORMATION*/WAIVER**

*Questions 1& 2 pertain to PPO product applicants only
**Complete Question 3 only if you are waiving (declining) any of the coverage available to you through your employer

1. Have you or any of your dependents had any other medical coverage in the last 12 months? ☐ YES ☐ NO
   (If yes, answer Question 2) Will this coverage be terminated? ☐ YES ☐ NO If yes, date of termination _____

2. Insurance Company Name (Attach separate sheet if necessary) _____
   Coverage Start Date _____ Coverage End Date _____
   Coverage Type: ☐ Group Policy ☐ Individual Policy ☐ Medicare/Medicaid ☐ Other _____
   Is this coverage through your spouse's employer? ☐ YES ☐ NO If yes, provide employer's name _____
   Name of policyholder _____
   Policyholder Date of Birth & SSN _____ Relationship to applicant _____
   Please list names of other family members with other continuing medical coverage (including Medicare)_____
   _____
   Medicare effective date (Parts A & B) _____ Reason for Medicare eligibility ☐ Over 65 ☐ Disabled ☐ Kidney Disease
   Medicare Claim Number _____ (Please attach copy of Medicare ID card)

3. This is to acknowledge that I have been given opportunity to apply for group coverage available to me and my dependents pursuant to state law through the above named employer.
   I hereby waive group coverage for: ☐ Myself ☐ My Spouse ☐ Dependent Children

   I decline to apply for group coverage because: ☐ Spousal Coverage ☐ Individual health coverage ☐ Medicare Supplement
   ☐ Coverage under another carrier's plan provided by the named employer ☐ Other _____

   I represent that I was not pressured or induced by my employer, any insurance agent, Or Community First into waiving (declining) the group health insurance coverage offered by my employer.

   I understand that if I do not enroll myself or my dependents during the current enrollment period, I will not be able to enroll myself or my dependents until the next annual Group Enrollment Period, except in special circumstances listed below:

   - If you are declining enrollment for yourself or your dependents because of other health coverage, you may be able to enroll yourself or your dependents for this group health coverage, if you request enrollment within 31 days after the other coverage ends.
   - If you have a new dependent as a result of marriage, birth, adoption, placement for adoption or suit for adoption, you may be able to enroll yourself and your dependents for group health insurance coverage, if you request enrollment within 31 days after the marriage, birth, adoption, placement for adoption or suit for adoption.
   - If you are ordered by a court to provide group health insurance coverage for a spouse or child, you may also enroll for coverage if you request coverage within 31 days after your employer receives official notice of the court order.

   Employee Signature _____ Date _____

SECTION 6: ACKNOWLEDGEMENT OF COVERAGE (All eligible employees must sign and date, unless waiving all coverage)

I hereby acknowledge I have read the statement contained herein, or they have been read to me and the statements are true and complete to the best of my knowledge. I understand any intentional material false statement, misrepresentation or omission on this form which changes the risk assumed by this plan may cause loss of coverage under this plan, except that misstatements of Health Status will not be used to cancel, non-renew or void my coverage under this plan, but may result in an increase in premium. I hereby enroll for benefits for which I am presently eligible, or for which I may become eligible, under my employer's group contract(s). If any deductions are required for this coverage, I authorize such deductions from my earnings. I reserve the right to revoke this deduction authorization at any time upon written notice. I also authorize those providing services to me or my dependents to release, if permitted by law, relevant information on medical records to this plan.

Employee Signature (Required) _____ Date _____