

Instructions

1. Determine whether you want to enroll, decline coverage, or change information and complete the corresponding box.
2. Complete the section entitled "*General Information.*"
3. If you have life coverage, complete the beneficiary information in the section entitled "*Life Insurance.*"
4. If you are electing FBA coverage, complete the section entitled "*Flexible Benefit Account.*"
5. If you are electing medical or dental coverage, complete the section entitled "*Medical Coverage.*"
 - If you select the HMO or POS plan, be sure to select a Primary Care Physician (PCP) for yourself and each covered dependent. Your PCP will coordinate your medical care, providing most services and referring you to hospitals and specialists when necessary.
 - If you select the PPO plan, do not supply provider information.

If you need help selecting a PCP, contact Member Services.

6. Read the "*Disclosure Information*" on the back of the application.
7. Sign and date the application.
8. Remove this instruction card, keep the pink copy for your records and turn in the completed application to your plan administrator.

We look forward to meeting your family's health care needs.

Benefit Plan Enrollment/Change Form

ENROLLING				DECLINING COVERAGE	CHANGING INFORMATION																																								
Enrollment for: <input type="checkbox"/> Myself and my dependents (family coverage) <input type="checkbox"/> Myself only (single coverage) because: <input type="checkbox"/> I have no dependents <input type="checkbox"/> My dependents have other insurance <input type="checkbox"/> I don't wish to purchase dependent coverage		Plan Selections: <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th>Medical</th> <th>Ee</th> <th>Ee & Sp</th> <th>Ee & Ch</th> <th>Family</th> <th>Dental</th> <th>Ee</th> <th>Ee & Sp</th> <th>Ee & Ch</th> <th>Family</th> </tr> </thead> <tbody> <tr> <td>HMO</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Dental+</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>POS</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Indemnity Dental</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>PPO</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>POS Dental</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </tbody> </table>		Medical	Ee	Ee & Sp	Ee & Ch	Family	Dental	Ee	Ee & Sp	Ee & Ch	Family	HMO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dental+	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	POS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Indemnity Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PPO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	POS Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reason: <input type="checkbox"/> I have other insurance <input type="checkbox"/> Other _____ My signature below certifies that I understand the availability of health coverage.	<input type="checkbox"/> Updating General Information <input type="checkbox"/> Transferring to a different plan <input type="checkbox"/> Changing PCPs <input type="checkbox"/> Adding a dependent <input type="checkbox"/> Changing FBA salary redirection amount
Medical	Ee	Ee & Sp	Ee & Ch	Family	Dental	Ee	Ee & Sp	Ee & Ch	Family																																				
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General Information (always complete this section)				Life Insurance			Flexible Benefit Account			
Name Last	First	MI	Occupation	If your employer is paying the full cost for this coverage, you are automatically covered under this benefit.			Premiums will be deducted from my paycheck on a before-tax basis. I give my employer permission to reduce my salary by the following election amounts. FBA premiums are in addition to medical premiums deducted.			
Street			Daytime Telephone (____)_____	Evening Telephone (____)_____	Beneficiary	Relationship	%	Eligible Health Care Expenses (annual) <input type="checkbox"/> I wish to redirect: \$ _____ employee's election amount \$ _____ employer's contribution (if any) <input type="checkbox"/> I do not wish to redirect any money for health care expenses		
City State Zip Code			Email address _____							
County			Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		<input type="checkbox"/> Married Date of Marriage ____/____/____		Eligible Dependent Care Expenses (annual) <input type="checkbox"/> I wish to redirect: \$ _____ employee's election amount \$ _____ employer's contribution (if any) <input type="checkbox"/> I do not wish to redirect any money for dependent care expenses			
Social Security Number			Date of Marriage ____/____/____							

If you are applying for any Great-West coverage, including life coverage, you must answer the following question. You will not be individually denied coverage, or be charged different rates as a result of your answer. This information is not required if you are **only** applying for HMO medical coverage.

During the last 24 months, have you or any dependents been diagnosed with, or treated for, any adverse health conditions, including cancer, heart, lung, kidney, or liver diseases, diabetes, AIDS, ARC, brain disorders, or received an organ transplant, or incurred medical expenses which accumulated to more than \$10,000 or been scheduled for surgery or an organ transplant? Yes No Condition? _____

For all Coverages				Medical Coverage		
Name (Last, First, M.I.)	Date of Birth/Relationship	Sex	Full-time Student	Primary Care Physician (Last, First, M.I.) Please list name(s) exactly as they appear in the directory		Existing Patient?
Self	/ /	<input type="checkbox"/> M <input type="checkbox"/> F		PCP	Medical Group	<input type="checkbox"/> Yes <input type="checkbox"/> No
				Address _____		
Spouse	/ /	<input type="checkbox"/> M <input type="checkbox"/> F		PCP	Medical Group	<input type="checkbox"/> Yes <input type="checkbox"/> No
Social Security Number				Address _____		
Child	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	PCP	Medical Group	<input type="checkbox"/> Yes <input type="checkbox"/> No
Social Security Number				Address _____		
Child	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	PCP	Medical Group	<input type="checkbox"/> Yes <input type="checkbox"/> No
Social Security Number				Address _____		
Child	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	PCP	Medical Group	<input type="checkbox"/> Yes <input type="checkbox"/> No
Social Security Number				Address _____		

I understand that the choices I have indicated above must remain in effect for the entire plan year unless I have a change in family status or employment status and that any unused balances in either account at the end of a plan year shall be forfeited.

To be Completed by Employer	
Company Name	
Date of Full-time Employment	Div/Location
Orig. Eff. Date of EE's Coverage	Orig. Eff. Date of Dep's Coverage
Earnings \$ _____	
<input type="checkbox"/> Hourly	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
<input type="checkbox"/> Bi-Monthly	<input type="checkbox"/> Yearly
Hours worked per week? _____	
Is employee/dependent on COBRA continuation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, attach copy of original COBRA enrollment form.	

By my signature below, I acknowledge that I have read and understand the disclosure on the back of this application. I authorize the required payroll deduction for contributory benefits. I also represent that all information shown on this application is correct.		
Employee Signature		Date (MM/DD/YYYY)
For Company Use Only		
Plan Number	Effective Date	
Division	Late App	Class/Benefit Group

Disclosure Information

I hereby apply for all non-contributory coverages under my employer's plan and any contributory coverages that I have elected on the front of this application.

Life and/or disability income coverage

I understand that I must satisfy the eligibility and actively at work requirements at my employer's usual place of business on the date coverage for myself and any eligible dependents becomes effective. If I am not actively at work, I understand that coverage for myself and life coverage for my eligible dependents may not become effective until I return to work. I will be considered a late applicant if I decline any contributory coverage offered under this application and later apply. As a late applicant applying for coverage, I understand that proof of good health may be required for myself and eligible dependents.

FBA Coverage

If I have elected to redirect money for eligible dependent care expenses, I have considered the IRS tax credit available to me. I understand that if I am married and filing a separate tax return, a lower maximum applies.

Health coverage

I understand that I must submit a Certificate or evidence of prior creditable coverage to receive credit towards the satisfaction of any pre-existing condition limitation specified in my employer's plan; and to be eligible for credit, the gap between the two coverages must be 63 days or less.

I and/or my eligible dependent(s) will be considered a "Special Applicant" if:

- I did not previously elect to cover myself and/or my eligible dependent(s) under my employer's policy/plan because of other health coverage and I later apply because the other coverage terminated involuntarily; or
- I did not previously elect to cover myself and/or my eligible dependent(s) and I later apply for coverage because of a change in my family status resulting from marriage, birth or adoption of a child.

I understand that to qualify as a "Special Applicant" I must apply for health coverage for myself and/or my eligible dependent(s) within 31 days after:

- Coverage under the prior health plan ends; or I marry; or I acquire a new child through birth, adoption or placement of a child for adoption.

I understand that health coverage is available to me and that I may experience special requirements if I do not enroll at this time. I will be considered a late applicant if:

- I fail to qualify as a "Special Applicant" because I did not apply within the 31 days as specified above; or
- I did not previously elect to cover myself and/or my eligible dependents and I later apply.

As a late applicant applying for health coverage, I realize that I may only be allowed entrance to the plan during the open enrollment period. As a late applicant, I realize that my entry to the plan may be subject to special enrollment requirements and that I must contact my Plan Administrator for details.

For all coverages

I hereby authorize any insurance company, health care provider, or other entity or person having knowledge of anyone listed on this application to give this new carrier or their designated agent(s) any and all records pertaining to such person's medical history for purposes of review, investigation or evaluation. For application purposes, this authorization is valid for 30 months from the date I sign it. For purposes of claims, reimbursement and receipt of services rendered, this authorization is valid during the term of such person's coverage for evaluation of the nature and medical necessity of the services received. I am, or my authorized representative is, entitled to a copy of this signed authorization.

California residents - I understand that any differences between myself (and/or my dependents) and One Health Plan, including any claim of medical malpractice, will be resolved through One Health Plan's grievance process, up to and including binding arbitration. Under this coverage, both the member and One Health Plan are giving up the right to have differences decided by jury trial or by a court, except as state law provides for judicial review of arbitration proceedings. Any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Colorado residents - It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

New Jersey residents - Different providers in our network have agreed to be paid in different ways by us. Your provider may be paid each time she or he treats you (fee for service). These payment methods may include financial incentive agreements to pay some providers more (bonuses) based on many factors; member satisfaction, quality of care, and control of costs and use of services among them. If you desire additional information about how our primary care physicians or any other providers in our network are compensated, please call Member Services at the telephone number shown in your enrollment kit.

Florida residents - (1) I have received educational material regarding Advance Directives from One Health Plan of Florida, Inc. as required by state regulations. I understand that if I wish to have Advance Directives I need to contact my primary care physician and supply him/her with a copy of my wishes. I can receive more education about Advance Directives by contacting my primary care physician. (2) Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Georgia residents - I understand it is my responsibility to review the number, mix and distribution of participating providers available on line at www.onehealthplan.com or by calling Member Services at 1-800-663-8081. Physicians are reimbursed on a fee for service basis.

Tennessee residents - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

Residents of all other states - Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

This Disclosure Information forms a part of the *Application for Membership* as fully as if it were contained over the applicant's signature.