HealthSCOPE BENEFITS

TO BE COMPLETED BY EMPLOYER – GROUP VLEMS

DATE OF REQUEST _____EFFECTIVE DATE_____

REASON FOR CHANGE: ☐ New Hire ☐ Open Enrollment ☐ Reinstate ☐ Change ☐ Add ☐ Drop ☐ Term ☐Other

EMPLOYEE STATUS: ☐ Actively Employed ☐ Retired ☐ Other

ENROLLMENT APPLICATION, CHANGE & TERM NOTICE

(PLEASE PRINT)

EMPLOYEE LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NO.	BIRTHDATE / /	SEX ☐ MALE ☐ FEMALE
STREET ADDRESS	CITY	STATE	ZIP CODE	COUNTY	
PHONE NUMBER(S)	Plan Election ☐ Silver RBP ☐ Gold RBP ☐ Bronze RBP		Plan Election ☐ Gold UHC Network		
DATE OF EMPLOYMENT / /	MARITAL STATUS ☐ Single ☐ Married ☐ Widowed ☐ Divorced	EMPLOYEE CLASSIFICATION Active - ☐ Certified ☐ COBRA	TYPE OF COVERAGE ☐ MEDICAL ☐ Emp. Only ☐ Emp. + Spouse ☐ Emp. & Children ☐ Family		

EMPLOYEE AND/OR DEPENDENT INFORMATION

COMPLETE THE FOLLOWING INFORMATION FOR YOURSELF AND EACH DEPENDENT TO BE COVERED BY THE PLAN

(Please add additional sheet if necessary)

LAST NAME	FIRST NAME	M.I.	RELATIONSHIP	SEX	BIRTHDATE	SOCIAL SECURITY #	FULL-TIME STUDENT*
			SELF				
			SPOUSE				

EMPLOYEE AND/OR DEPENDENT DROP OR TERMINATION NOTICE

CHANGE	COBRA EVENT	If Dependent Change only, list applicable dependent	Other change? List below
☐ Employee Drop ☐ Employee Termination ☐ Dependent Drop/Termination ☐ EE Change to Retiree	☐ Termination of Employment ☐ Reduction in Hours ☐ Divorce Date _____ ☐ EE Death _____ ☐ EE Medicare Date _____ ☐ Dependent Ineligibility		

COORDINATION OF BENEFITS INFORMATION

Is there any other health insurance in force for you or any family member? ☐ YES (answer the following) ☐ NO

NAME OF POLICYHOLDER	POLICY NO./SOCIAL SECURITY #	BIRTHDATE / /
INSURANCE COMPANY NAME AND ADDRESS	EMPLOYER THROUGH WHICH POLICY IS HELD (if any)	EFFECTIVE DATE OF COVERAGE / /

TYPE OF POLICY: ☐ HOSPITALIZATION ☐ MAJOR MEDICAL ☐ VISION ☐ DENTAL ☐ OTHER _____

IF MEDICARE, CHECK ONE: ☐ MEDICARE A (hospital) ☐ MEDICARE B (medical) ☐ BOTH A & B

TYPE OF COVERAGE: ☐ EMPLOYEE ☐ EMPLOYEE + SPOUSE ☐ EMPLOYEE + 1 CHILD ☐ FAMILY

If Family, list individuals covered:

WAIVER

I have read and understand the material explaining the available coverage options and have elected NOT to enroll.

EMPLOYEE SIGNATURE: _____ DATE: _____

I have read and understand the material provided explaining the coverage options and have elected to enroll in this program. I understand the members covered under my contract should adhere to the provisions of the program. To all persons or institutions licensed to provide health care, pharmacies, educational institutions, and other agencies (including insurance companies): You are authorized to permit HealthSCOPE Benefits or its representatives to obtain or view a copy of my medical, health care, or school records on the above named patient(s).
HealthSCOPE Benefits is authorized to use, release, disclose, or discuss in person or telephonically the information to the extent necessary to determine the value or amount payable on any claim, to ensure proper and correct policy / contract administration, and as needed for medical case management. This authorization, or a photographic copy thereof, is valid for the term of coverage of the policy or contract under which a claim has been submitted, I understand that a copy of this authorization is available to me upon request.
I hereby represent that all information furnished is true and complete to the best of my knowledge.

EMPLOYEE SIGNATURE: _____ DATE: _____

GROUP ADMINISTRATOR: _____ DATE: _____

NOTE: If the above information changes, please contact your employer to update your information.

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