Health First Health Plans

Enrollment/Change Form

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EMPLOYER NAME	GROUP #	POLICY #

Section I. Type of transaction

___**Enrollment** (✓ all that apply)	___**Waive Enrollment** (✓ all that apply, complete Section IV)	___**Change** (✓ all that apply, complete Section III)
___Employee ___Spouse ___Child(ren)	___Employee ___Spouse ___Child(ren)	___Name ___Plan ___Coverage ___Address ___Division ___PCP ___Termination ___Dependent termination

Section II. Employee/applicant information

___New group enrollment ___New hire ___Open enrollment ___Qualifying event (include required documentation) ___Add dependent

Applicant SSN	Plan name and type ___HMO ___POS		Eff. date of coverage/ change/termination
Applicant last name	First name	MI	E-mail

Home street address	City	State	Zip

Phone #	___Employee ___Retiree	Hire/retirement/ rehire date	Occupation

Section III. Enrollment/change information

Name ↓	Type of change (A=add, C=change, T=termination) ↓	Relationship to applicant	Social Security #	Sex	Date of birth	Primary Care Physician	New patient? (Y/N)	Employed full time? (Y/N)
Applicant		**N/A**						**N/A**
Dependent								
Dependent								
Dependent								
Dependent								

- **Does any dependent listed above have a permanent residence that is different than the applicant?** ____No ____Yes
  If yes, provide name of dependent and address:

- **Does any dependent child listed above have a permanent physical or mental handicap?** ____No ____Yes
  If yes, provide name of dependent and at what age the handicap commenced:

- **Please provide the following information on your previous type of health coverage:**
  (✓ all that apply) Persons covered: __Self __Spouse __Child(ren) **Type of coverage**: __Group __Individual __Gov't. program
  Carrier name Policy number Effective date Termination date

- **Does anyone listed above carry health coverage in addition to this group plan?** ___No ___Yes (if yes, please provide the following:)
  Name Carrier Policy #

Section IV. Waive coverage (if applicable)

I am declining coverage for: (✓ all that apply)	**Reason for declining coverage** (✓ all that apply, provide copy of ID card)
___Myself ___Spouse ___Child(ren)	___Other group coverage ___ Medicare ___TriCare ___No coverage

I hereby elect the above enrollment or change to my enrollment with Health First Health Plans, Inc. I authorize my employer to deduct from my earnings my share of the payment for coverage and to make any necessary payments to the plan. I authorize those providing services to me to release relevant information or medical records (may contain HIV/AIDS, psychiatric and/or chemical dependency treatment information) to the plan. Plan agrees to comply with all HIPAA privacy regulations.

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.

EMPLOYEE SIGNATURE DATE