Saint Mary's Health Plans
HealthFirst
A member of CHW

For office use only:

Group #:_____ Effective Date:_____ Benefit Code:_____

HMO/POS ENROLLMENT/CHANGE AND TERMINATION FORM –PLEASE PRINT*

***Forms completed electronically will still need a signature**

Medical Plan selected: _____

Please check as appropriate: ☐**Open Enrollment** ☐**New Hire** ☐**New Enrollee** ☐ **COBRA**

☐ New Application Effective Date____/____/____
☐ Remove Dependent Term Date____/____/____
☐ Add Dependent Event Date____/____/____
☐ Terminate Coverage Term Date____/____/____

☐ Address Change
☐ Name Change
☐ PCP Change
☐ Other: _____

Qualifying Event_____
_____
Date of Qualifying Event ___/___/___
____18 _____ 29 _____ 36 months

EMPLOYEE				
	Name (Last, First Middle Initial):			☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
	Home Address (Street):	City, State	Zip:	Home Phone Number:
	Mailing Address (if different from above:)	City, State	Zip:	E-mail Address:
	Employer Name:			Department / Site:
	Date of hire (Mo/Day/Yr):	Work Phone Number:	☐ Full Time ☐ Part Time	Hours Worked Per Week:

Type of Coverage Elected: ☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Employee & Family ☐ Domestic Partner

Name (Last, First Middle Initial)	Social Security Number	Gender (circle)	Date of Birth mo/day/yr	Primary Care Physician Name	Check if now a patient	Secondary PCP (OB/GYN)	Check if now a patient
#1-Employee		M F					
#2-Spouse		M F					
#3-Dependent		M F					
#4-Dependent		M F					
#5-Dependent		M F					

After enrolling in Saint Mary's HealthFirst, will you or your dependents have any other insurance? ☐ Yes ☐ No
If yes, please provide the information below:

Does Member have Medicare A? ☐ Yes ☐ No / Medicare B? ☐ Yes ☐ No Medicare #_____
Insurance Company:_____Insurance Carrier Phone #:_____ Effective Date: _____

Policy #::_____ Group #:_____ Policy Holder: _____

Is your spouse employed? ☐ Yes ☐ No Employer:_____

Insurance Company:_____ Insurance Carrier Phone # _____ Effective Date: _____

Policy #:_____Group #:_____ Policy Holder: _____ Effective Date:_____

Will dependents be covered by spouse's insurance? ☐ Yes ☐ No If yes, please list names below:
1. _____ 2. _____ 3. _____

On my behalf and for my enrolled dependents, I hereby (1) apply for healthcare coverage through Saint Mary's HealthFirst, (2) agree to abide by all policies and procedures of Saint Mary's HealthFirst including eligibility, benefits, exclusions, limitations and other terms of the Evidence of Coverage; (3) authorize any physician, hospital or other healthcare provider to release to Saint Mary's HealthFirst any and all medical information and records as requested for the administration and management of Saint Mary's HealthFirst as well as for medical purposes, (4) to cooperate with and provide any and all consent, releases and other assignments necessary for Saint Mary's HealthFirst to coordinate the benefits of this and any other insurance or coverage; and (5) to make required copayments as detailed in the Evidence of Coverage and Summary of Benefits.

If coverage is approved and accepted, I authorize any payroll deduction necessary for the coverage that I have elected. I certify that the above information is correct to the best of my knowledge and belief. I agree that a copy of this authorization shall be valid as the original.

Employee Signature _____ Date_____