Lovelace
Health Plan

Enrollment/Change Form

Lovelace Health System, Inc. • Lovelace Insurance Company

F	FOR INTERNAL USE ONLY	
	Member # LH–	
	Processed by	Date

Employer: Complete Section A, E
Employee: Complete Sections B, C, D, E
Health Plan: Complete Section F

Please **print clearly and complete each section of this form**.
Thank you for providing this information.
Illegible and/or incomplete forms will be returned and will delay processing

A

❑ Open Enrollment ❑ Change ❑ New Enrollment ❑ Reinstate ❑ Other (reason) ______	Employee Title	Date of Hire	Hours Worked	Effective Date of Coverage	Employer Name	LHP/LINC Group No.	Subgroup No.	Class

TYPE OF CHANGE
❑ **Address Change**
❑ **Add Dependent(s)***
❑ Birth ❑ Marriage ❑ Adoption Placement ❑ Other
Date of Change

❑ **Cancel Employee**
❑ Termination of Employment
❑ Other Insurance
❑ Other
Date

❑ **Cancel Dependent(s)***
* List Name in Section B
❑ Marriage ❑ Divorce
❑ Other
Date of Above Event

❑ **Transfer to Cobra**
* List Name in Section B
❑ 18 mos.
❑ 29 mos.
❑ 36 mos.
– or –
❑ 6-month State continuation
❑ Family Security Benefit/ Surviving Spouse
❑ Retirement
❑ Other

B

Employee Name (LAST)	(FIRST)	(M.I.)	Social Security No.	Date of Birth	Employee Gender ❑ M ❑ F	Home Phone ( )

Physical Address (STREET, CITY, STATE, ZIP)	E-mail Address	Work Phone ( )
Mailing Address (STREET, CITY, STATE, ZIP)	Primary Care Physician (PCP)	Existing Patient of PCP? ❑ Yes ❑ No

I WOULD LIKE COVERAGE FOR MY DEPENDENTS (*).
(Specify last name if different from yours)
If enrolling more than 3 dependents use a second form

Last Name (if different than yours) First Name M.I.	Relationship	Social Security Number	Date of Birth Mo./Day/Year	GENDER	**Primary Care Physician** Provide First AND Last name of physician. *Please indicate the provider number from the Lovelace provider directory (if directory is available to you). If none is selected, one will be assigned to you.*	Existing Patient
Spouse/Domestic Partner	❑ Spouse ❑ Domestic Partner Date of Marriage___ /___ /___ City, State in which married ________			❑ M ❑ F		❑ Y ❑ N
Dependent*	❑ Son ❑ Daughter ❑ Other ❑ Natural Child ❑ Adopted ❑ Stepchild ❑ Employee Legal Guardian of Child ❑ Court-ordered coverage ❑ Physical/Mentally Impaired (*)			❑ M ❑ F		❑ Y ❑ N
Dependent*	❑ Son ❑ Daughter ❑ Other ❑ Natural Child ❑ Adopted ❑ Stepchild ❑ Employee Legal Guardian of Child ❑ Court-ordered coverage ❑ Physical/Mentally Impaired (*)			❑ M ❑ F		❑ Y ❑ N
Dependent*	❑ Son ❑ Daughter ❑ Other ❑ Natural Child ❑ Adopted ❑ Stepchild ❑ Employee Legal Guardian of Child ❑ Court-ordered coverage ❑ Physical/Mentally Impaired (*)			❑ M ❑ F		❑ Y ❑ N

(*) If physically or mentally impaired and over the group limiting age, please attach medical records for eligibility review.

C

Medical Coverage Options:	**Offered by Lovelace Health System, Inc.**		**Offered by Lovelace Insurance Company**
	❑ Platinum Coverage	❑ Select Coverage	❑ Select PPO Coverage
	❑ Premier Coverage	❑ Point of Service	❑ Classic PPO[1] (submit Certificate of Creditable Coverage, if applicable)
	❑ Primary Coverage	❑ Individual Conversion	❑ Classic Plus PPO[1] (submit Certificate of Creditable Coverage, if applicable)

D

Other Health Care Coverage:
Do you or your dependents have other health insurance under a group plan, HMO, or Medicare? ❑ Yes ❑ No
If yes, please provide the following

Name of Person Covered	Date of Birth	Employee Name	Employer Name	Member ID #	Insurance Co. Name and Address	Type of Coverage	Medicare Part A B D	
							❑ ❑ ❑	❑ Medicare End-Stage Renal Disease
							❑ ❑ ❑	❑ Medicare End-Stage Renal Disease

E

I have read the descriptive literature outlining the medical plan and I hereby apply for participation in said plan. I authorize my employer to deduct from my earnings the employee's contribution, if any, to the premium under the Agreement (contract). I also authorize the health care provider from which I or my dependents receive health care services to disclose to the Insurer any information concerning me or my dependents contained in the records of the health care provider. I understand that membership may be automatically terminated if I have given any fraudulent information regarding myself or dependents on this application. I agree that all sums payable by other health plans (including Medicare, Medicaid, Champus and Workers Compensation) shall be payable to and retained by the Insurer. I agree for myself and my dependents to complete and submit to the Insurer such consents, releases, assignments and other documents requested by the Insurer to assure such payment.

SIGNATURE – The information provided above is complete and correct to the best of my knowledge. I agree on behalf of myself and my covered dependents to the provisions this form.

Subscriber Signature ____________ Date ______ Employer Verfication Signature ____________ Date ______

PLEASE RETURN ORIGINAL TO ELIGIBILITY SERVICES, PO BOX 6112, WESTERVILLE, OH 43086-6112 OR FAX TO 614-212-7060

FOOTNOTES

1 This plan imposes a Pre-existing Condition exclusion. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. If you have prior health/creditable coverage, please attach your HIPAA Certificate of Credible Coverage with this application.

PROVISIONS

I authorize deductions from my earnings of the required contributions, if any, toward the cost of the coverage. This authorization applies only if employee contributions are required.

APPLICABLE TO BENEFITS

- I authorize payment of any and all benefits payable under the policy to any licensed provider of care who treats me and/or my covered dependents.
- Lovelace Health System, Inc. or Lovelace Insurance Company provides health coverage under an agreement with my employer.
- I understand that the Participating Providers, if any, do not necessarily include all types of doctors or providers.
- I authorize any Provider, Insurance Company, Employer or Organization to release necessary information on me or my dependents regarding medical, dental, mental health or substance abuse history, treatment or benefits payable, to the Plan Administrator, its authorized agent, the Insurer entity administering this plan or my primary care physician for the purpose of determining benefits in connection with this plan or quality assessment purposes. This authorization for release of substance abuse history, treatment or benefits payable is subject to revocation at any time except to the extent that disclosure of such information has already been made to the Plan Administrator, its Authorized Agent, the Insurer entity administering this plan or my primary care physician.
- I authorize payment of any and all benefits payable under the policy to the Participating Provider of the benefits who treats me and/or my covered dependents.
- I authorize that payment be made under Medicare to the Insurer for medical and other services furnished me for which it pays or has paid, if applicable.
- I agree, for myself and my dependents, that, in the event any health services provided are the primary responsibility of any other party by way of other group health coverage or by the act or omission of another person to fully inform the Insurer and will execute such assignments, liens or other documents which may be necessary to enable the Insurer to recover the value or the services provided. I further agree that in the event I or any of my dependents collect benefits or damages from any other party who has primary responsibility for the services provided by the Insurer I will immediately reimburse the Insurer to the extent of the services provided, to the extent permitted by state law.
- All statements, in the absence of fraud, made by the Member or Subscriber shall be deemed representations and not warranties, and that no such statement shall void the insurance or reduce benefits there under unless contained in a written application for such insurance.

LATE ENROLLMENT

- Late enrollments will not be accepted.

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

I understand that it is necessary for the parties administering the plan in which I am enrolling to obtain and/or provide to others "Confidential Information," as defined below. Therefore:

- I authorize any person or entity having Confidential Information to provide any such Confidential Information upon request to the Insurer, any Participating Provider, or any other provider or entity performing a service for the purpose of eligibility determination under the plan, the administration of the plan, the performance of any insured program or operations, or assessing quality and accessibility of heath care services and supplies.
- I authorize the Insurer to disclose any Confidential Information to any person, company, or entity when it determines that such disclosure is necessary or appropriate for the administration of the plan, the performance of insured programs or operations, assessing quality and accessibility of health care services and supplies, or reporting to third parties involved in plan administration.
- I am making this authorization for myself and as the agent or representative of my covered dependents OR representative of my spouse, domestic partner (if applicable) and any dependent children. I understand that it will remain in effect until I send written notice revoking it to the Insurer or for such shorter period as required by law. Until revoked, this authorization may be relied upon by the Insurer and other parties. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.
- "Confidential Information" means, with respect to me and any covered dependents, any medical, dental, mental health, substance abuse, communicable disease, AIDS and HIV related information and disability or employment related information.
- "Insurer" means Lovelace Health System, Inc. and Lovelace Insurance Company.