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EC \_\_\_\_\_

### Commercial Group Health Insurance Application/Change Form

**CONFIDENTIAL**

Please print clearly and complete all sections that apply. Signatures are required. Additional instructions included on Page 4.

#### Section 1: Employer Group & Benefit Information To be completed with your Group Administrator

Employer Name _____		Association/Chamber Name (if applicable) _____		<b>Check Desired Action</b> <input type="checkbox"/> Add <input type="checkbox"/> Cancel <input type="checkbox"/> Change	
Group Administrator's Signature (required) _____		Date _____		Employee Number _____	
				Department Number _____	

<b>Medical Information</b>		<b>Who's covered?</b> <input type="checkbox"/> Self Only <input type="checkbox"/> Self & Child(ren) <input type="checkbox"/> Self & Spouse/Domestic Partner <input type="checkbox"/> Family		<b>Subscriber Status:</b> <input type="checkbox"/> Actively Working <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Canceled <input type="checkbox"/> COBRA	
Medical Group Number (8 digits) _____		_____ / _____ / _____ <b>Medical Effective Date</b>		<b>Dental Information</b>	
Subgroup _____ Class _____				Dental Group Number _____	
				Subgroup _____ Class _____	
				_____ / _____ / _____ <b>Dental Effective Date</b>	

<b>Medical Plan Selection</b>		<b>Dental Plan Selection</b>	

<b>Medical Plan Selection</b>		<b>Vision Information</b>		<b>Who's covered?</b> <input type="checkbox"/> Self Only <input type="checkbox"/> Self & Child(ren) <input type="checkbox"/> Self & Spouse/Domestic Partner <input type="checkbox"/> Family	
		Vision Group Number _____		_____ / _____ / _____	
		Subgroup _____ Class _____		<b>Vision Effective Date</b>	
		<b>Vision Plan Selection</b>			

#### Section 2: Subscriber's Information

Last Name _____		Birth Date _____ / _____ / _____		Retirement Date _____ / _____ / _____	
First Name _____		Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Gender X		<input type="checkbox"/> Age 65+ <input type="checkbox"/> Disability <input type="checkbox"/> End Stage Renal *	
Middle Initial _____ Title (e.g., Jr, Sr, III, etc.) _____		Social Security Number** _____		Subscriber's Medicare Number (if applicable) _____	
Street Address _____		Date of Hire/Rehire _____ / _____ / _____		_____ / _____ / _____ <b>Medicare Part A Effective Date</b>	
City _____ State _____				_____ / _____ / _____ <b>Medicare Part B Effective Date</b>	
Zip Code _____ Phone _____		<div style="border: 1px solid black; padding: 5px;">           You must fill out the following section: Would you like to be added to the Donate Life Registry? <input type="checkbox"/> Yes <input type="checkbox"/> Skip this question         </div>			
		Primary Care Physician's Last Name _____ First Name _____ Zip Code _____			
		Ob/Gyn's Last Name _____ First Name _____ Zip Code _____			

**Section 3: Reason for enrollment or change** To be completed by the Group Administrator Not required for cancellations

**Enrollment Opportunity:**  New Hire  Rehire  Open Enrollment  Medicare eligible

**Special Enrollment Opportunity:**  Newly Eligible Dependent:  Newborn  Marriage  Other \_\_\_\_\_

Change in employment status  A move in or out of the service area

Involuntary loss of coverage  Former dependent regains eligibility

**Date of Event** \_\_\_ / \_\_\_ / \_\_\_\_\_

**COBRA Election - Please indicate the reason for COBRA if applicable:**

Left Employment/Retired  Divorce/Legal Separation  Loss of Student Status  Death of Spouse

Disability  Dependent Reached Max Age  Other: \_\_\_\_\_

**Demographic Change:**  Address  Birthdate  Subscriber Name  Dependent Name  Phone Number

**Section 4: Cancel Information - If canceling coverage, who are you canceling coverage for?**

Subscriber	Cancel Code:	Medical Cancel Date:	Dental Cancel Date:	Vision Cancel Date:	Coverage ends at 11:59 p.m. on date indicated
<b>Cancel Codes:</b> SB02-Left Employment SB58-Change in Employee Eligibility Status SB08-Subgroup Transfer* SB06-Employee No Longer Wants Coverage* (subscriber request) SB57- Layoff Without Benefits SB07-Deceased SB09-Enrolled in Error* SB44-Medicare Eligible (Moved to Medicare plan with same employer)		/ /	/ /	/ /	

\* = Not eligible for COBRA

Dependent(s)	Name:	Cancel Code:	Medical Cancel Date:	Dental Cancel Date:	Vision Cancel Date:
<b>Cancel Codes:</b> M002-Deceased* M005-Divorced M010-Overage Dependent M014-YA No Longer Qualifies* M013-Ineligible Dependent M003-Subscriber No Longer Wants to Cover Dependent* M007-Dependent No Longer Wants Coverage* M009-Marriage M011-No Longer a Student M004-Enrolled in Error* M008-Moved Out of Area* M040-Medicare Same Group*			/ /	/ /	/ /
* = Not eligible for COBRA			/ /	/ /	/ /

**Section 5: Information about who you would like coverage for (dependent information)**

Spouse  Domestic Partner  Dependent Child  Adult Disabled Dependent (Separate application form required)

Other \_\_\_\_\_

\_\_\_\_\_

**Last Name** (if different) Title **First Name** MI **Social Security Number** \*\*

**Gender:**  Female  Male  Gender X **Birthdate** \_\_\_ / \_\_\_ / \_\_\_\_\_

Is dependent a full-time student over age 19?  Yes  No Married?  No  Yes \_\_\_ / \_\_\_ / \_\_\_ Expected Graduation Date: \_\_\_ / \_\_\_ / \_\_\_

If yes, please provide name of college/university \_\_\_\_\_ Will dependent further education after graduation?  Yes  No

Medicare Eligible  Yes  No If yes, indicate reason  Age 65+  Disability  End Stage Renal \*

Part A Effective Date: \_\_\_ / \_\_\_ / \_\_\_ Part B Effective Date: \_\_\_ / \_\_\_ / \_\_\_

Medicare Number (if applicable) \_\_\_\_\_

Primary Care Physician's Last Name First Name Zip Code Ob/Gyn's Last Name First Name Zip Code

↓ Additional Dependent(s) ↓

Dependent Child  Adult Disabled Dependent (Separate application form required)  Other \_\_\_\_\_

\_\_\_\_\_

**Last Name** (if different) Title **First Name** MI **Social Security Number** \*\*

**Gender:**  Female  Male  Gender X **Birthdate** \_\_\_ / \_\_\_ / \_\_\_\_\_

Is dependent a full-time student over age 19?  Yes  No Married?  No  Yes \_\_\_ / \_\_\_ / \_\_\_ Expected Graduation Date: \_\_\_ / \_\_\_ / \_\_\_

If yes, please provide name of college/university \_\_\_\_\_ Will dependent further education after graduation?  Yes  No

Medicare Eligible  Yes  No If yes, indicate reason  Age 65+  Disability  End Stage Renal \*

Part A Effective Date: \_\_\_ / \_\_\_ / \_\_\_ Part B Effective Date: \_\_\_ / \_\_\_ / \_\_\_

Medicare Number (if applicable) \_\_\_\_\_

Primary Care Physician's Last Name First Name Zip Code Ob/Gyn's Last Name First Name Zip Code

Dependent Child  Adult Disabled Dependent (Separate application form required)  Other \_\_\_\_\_

**Last Name** (if different) \_\_\_\_\_ **Title** \_\_\_\_\_ **First Name** \_\_\_\_\_ **MI** \_\_\_\_\_ **Social Security Number** \*\* \_\_\_\_\_

**Gender:**  Female  Male  Gender X **Birthdate** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Is dependent a full-time student over age 19?  Yes  No Married?  No  Yes \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Expected Graduation Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 If yes, please provide name of college/university \_\_\_\_\_ Will dependent further education after graduation?  Yes  No

Medicare Eligible  Yes  No If yes, indicate reason  Age 65+  Disability  End Stage Renal \*  
 \_\_\_\_\_ Part A Effective Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Part B Effective Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Medicare Number (if applicable) \_\_\_\_\_

Primary Care Physician's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Zip Code \_\_\_\_\_ Ob/Gyn's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Zip Code \_\_\_\_\_

**Note: Use an additional application or addendum if more than three dependents need coverage**

**Section 6: Other coverage information (Required) - You may be contacted for additional information**

Have you or any member of your family been enrolled in other medical or dental coverage?  Yes  No  
 If yes, what type of coverage?  Medical  Dental  
 What is the effective date of the other coverage?  Medical: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  Dental: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 What is the name of the other carrier? \_\_\_\_\_  
 Are you keeping the coverage?  Yes  No  
 If no, when will the coverage end?  Medical: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  Dental: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Policyholder's name \_\_\_\_\_ ID#(s) \_\_\_\_\_  
 Who did the insurance cover?  Self Only  Self & Spouse/Domestic Partner  Self & Child(ren)  Family

**Section 7: Release - You must sign and date this form to be eligible for health insurance**

I acknowledge and agree that by signing this enrollment form and subsequently accepting services, I and everyone else who is covered under the contract you issue is bound by the terms and conditions of the contract applicable to my coverage. This includes, without limitation, the terms and conditions regarding the receipt and release of medical records and information. I make this acknowledgment and agreement on behalf of myself and each other person who accepts coverage under the terms of the contract applicable to my coverage (who may include, for example my spouse and my eligible family dependents).

I hereby accept responsibility for payment of any portion of the premium.

I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

Pediatric dental is an essential health benefit mandated by the ACA. If your employer group does not provide pediatric dental coverage through this Univera Healthcare plan, you agree to enroll in the dental plan offered to you by your employer.

**HEALTH MAINTENANCE ORGANIZATION (HMO)** I understand that I have elected a Health Maintenance Organization (HMO) plan and that I am required to choose a Primary Care Provider (PCP) who will provide my primary care, oversee my other health care services, and, when required, obtain prior approval for certain services such as Inpatient Facility care. **POINT OF SERVICE (POS)** I understand that the Point of Service (POS) plan provides services on two benefit levels: in-network or out-of-network benefits. I understand that the in-network benefit provides the highest level of coverage under the plan and that I must choose a Primary Care Provider (PCP) to provide my primary care, oversee my other health care services, and, when required, obtain prior approval for certain services such as Inpatient Facility care.

I have thoroughly read, understand and agree to comply with the terms of the release in this section.

**Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation.**

**Subscriber Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Please return to P.O. Box 211256 Eagan, MN 55121-2656  
 If you have questions, please contact your Group Administrator. Or, visit us at: UniveraHealthcare.com

## Instructions for completing the Group Health Insurance Application/Change Form

### Section 1: Employer Group & Benefit Information

This section should be completed with your Group Administrator. Group Administrator's signature is required. Medical, dental and/or vision group numbers and information must be populated. Select who you need coverage for on the medical, dental and/or vision plan(s). Next, select the medical, dental and/or vision plan(s) you are enrolling in. All products may not be applicable to your employer group. Please check with your Group Administrator. Indicate the subscriber's status.

### Section 2: Subscriber's Information

This section should be completed by the Subscriber. \*\*We are required to ask for your social security number in order to meet our reporting obligations under the Affordable Care Act. \* There is additional information needed if eligible for Medicare due to ESRD. Please contact your Group Administrator for the appropriate form.

**Health Equity:** Health care should meet the needs of everyone—no matter who you are, where you live, or who you love. To learn more about health equity and view our privacy policy, visit [UniveraHealthcare.com/HealthEquity](http://UniveraHealthcare.com/HealthEquity).

**Donate Life Registry:** By checking 'Yes' and signing this application, you are consenting to enroll in the New York State Donate Life Registry (Registry). To modify your gift or withdraw from the Registry go to: [donatelifen.y.gov](http://donatelifen.y.gov) or call the Registry at 1-866-NY-DONOR.

### Section 3: Reason for enrollment or change

Select the box(es) that describe(s) the reason for this enrollment or change regarding health insurance coverage and include the date of the event. An event is a specific occurrence, due to change in status, marriage, divorce, birth or adoption, group's anniversary date, or rate change. Your request must be received within 30 days of the event date. Please see your Group Administrator for events that fall outside the 30-day period. You may be required to provide documentation of certain events.

### Section 4: Cancel Information - If canceling coverage, who are you canceling coverage for?

If you are canceling coverage, complete the appropriate section for who you are canceling. List the cancel code and enter the date(s) the coverage is to be canceled. List each applicable dependent to be canceled.

### Section 5: Information about who you would like coverage for (dependent information)

Please include information about all the people who you would like coverage for.

Use an additional application or addendum if more than three dependents need coverage.

If your dependents are Medicare eligible, complete the questions regarding Medicare coverage.

Qualified guidelines for coverage include:

- A legal spouse/domestic partner (An ex-spouse no longer qualifies as of the date court documents are stamped and filed with the county clerk)
- Must be under the eligible child age for your employer group including natural, adopted or stepchild(ren)
- Child(ren) Only coverage is available for children up to age 26 or 29 depending on the employer group coverage.
- There are additional eligibility requirements for dependents pending adoption, for which you are the legal guardian, and/or a disabled dependent who is over the maximum dependent age. Please contact your Group Administrator for the appropriate form.

\*\*We are required to ask for your social security number in order to meet our reporting obligations under the Affordable Care Act.

\* There is additional information needed if eligible for Medicare due to ESRD. Please contact your Group Administrator for the appropriate form.

A separate Adult Disabled Dependent application form is required for applicable dependents. Please contact your Group Administrator for the appropriate forms.

### Section 6: Other coverage information (Required)

Please include accurate information in this section. This could affect the processing of your application and/or claims.

### Section 7: Release

Subscriber signature and date are required in this section. The subscriber must sign the application prior to or within 30 days of the effective date or qualifying event date.