healthEZ

# Benefit Enrollment / Change Form

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| **Employee** | **First Name:** | **M.I.** | **Last Name:** | **SSN:** | **Gender:** ☐ Male ☐ Female |
| | **Mailing/Street Address:** | **Apt./Ste.** | **City:** | **State:** | **Zip Code:** |
| | **Birth Date:** | **Hire Date:** | **Marital Status:** ☐ Single ☐ Married ☐ Divorced | **Phone Number:** | **Email:** |

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| **Enrollment** | **Enrollment Type:** | ☐ New Hire | ☐ Open Enrollment | ☐ Qualifying Event | ☐ Decline (*See Decline Section*) |
| | **Qualifying Event Type:** (*If applicable*) | ☐ Marriage / Divorce | ☐ Birth / Death | ☐ Court Order | |
| | | ☐ Loss of Coverage | ☐ Reduction in Hours | ☐ Change Name / Address | |
| | | ☐ COBRA | ☐ Other _____ | | |

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| **Medical** | **Medical Plan Election:** | ☐ Copay Plan | ☐ Decline | |
| | **Medical Plan Coverage:** | ☐ Employee Only | ☐ Employee + Child(ren) | ☐ Employee + Spouse | ☐ Family |

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| **Dependents** | **Name** | **SSN** | **DOB** | **Relationship** | **Sex (M/F)** | **Disabled (Y/N)** | **Include on Plan** |
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| **Decline** | ☐ I understand the benefits provided by the Group Insurance Contract under ERISA regulations include Health and/or Dental coverages. I have reviewed and understand the benefit options and requirements presented herein. I understand that I may not be eligible to enroll myself and dependents if I desire to apply for coverage at a later date, unless I qualify to enroll at a later date in accordance with the special enrollment conditions. |

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| **Other Insurance** | ☐ **I do not have other insurance coverage** | ☐ **I have enrolled thru the state or federal Marketplace** |
| | ☐ **I have other insurance coverage** | ☐ **I have other insurance coverage, but intend to cancel that coverage** |
| | **Policy Holder Name:** | **Policy Holder Date of Birth:** |
| | **Insurance Company Name:** | **Insurance Company Address:** |
| | **Policy Number:** | **Group Number:** |
| | **Names of Covered Individuals:** | |

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| **Employee Authorization** | ☐ I understand I have the option to pay the premiums for my employer-sponsored health plan through a before-tax reduction of my salary. I understand that if this amount increases or decreases during the plan year, my salary reduction will be adjusted to reflect that increase or decrease. I hereby apply for the coverage for which I am now or may be eligible under this group policy. I hereby authorize the deduction from my earnings of the required contribution, if any, toward the cost of such coverage. I authorize payment of medical benefits to all providers, where applicable, for those charges covered by my group insurance benefits. I authorize release to or by HealthEZ of any medical information including copies of medical records or insurance information as necessary for claims adjudication, utilization review, or coordination of benefits.<br>☐ To the best of my knowledge and belief, the information I have provided on this form is complete and correct. I acknowledge that the terms of the Summary Plan Description govern all payments made by the Plans. |

_____ _____

Employee Signature Date