



Plan Name: Five Points Health Benefits, LLC

Group No: \_\_\_\_\_ Effective Date: ---/---/2024

Broker: \_\_\_\_\_

Open Enrollment  New Enrollment

Rehire Enrollment

## Self-Funded Employer Group Plan

Company name: \_\_\_\_\_  
 Plan Type: \_\_\_\_\_

### Enrollment Application

Coverage under FIVE POINTS BENEFIT PLANS is designed to assist participants in satisfying the Employer group mandate portion of the Affordable Care Act to receive the tax credit or subsidy before the next exchange open enrollment unless you have a qualifying life event.

**THIS INFORMATION MUST BE COMPLETED (even if your **WAIVING** coverage) – PLEASE PRINT in INK**

Please Note: **YOU MUST EITHER ACCEPT OR WAIVE COVERAGE** by completing and signing this form, even if you do not want coverage. Incomplete information will delay delivery of ID cards and processing of claims.

Are YOU Selecting Limited Benefit Plan 1 Coverage offered by your employer **for Yourself?**

Yes (Continue - You **must** sign the next page to Accept)  No (Continue - You **must** sign the next page to Waive)

Social Security Number: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Gender:  Male  Female Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Your Name: \_\_\_\_\_  
Last Name First Name Middle Initial Suffix (Ex: Jr, Sr.)

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Occupation: \_\_\_\_\_

Home Phone: ( \_\_\_\_\_ ) - \_\_\_\_\_ Cell Phone: ( \_\_\_\_\_ ) - \_\_\_\_\_

Email Address: \_\_\_\_\_ Date of Hire: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Plan \_\_\_\_\_:  EE Only |  EE+ Spouse |  EE+ Child |  EE+ Family

Are YOU Selecting Benefit Plan Coverage offered by your employer for **your spouse and or dependent child(ren)?**

**Yes (List Dependents below)**  **No (Skip to next page to ACCEPT or WAIVE for Yourself)**

ONLY LIST YOUR FAMILY MEMBERS TO BE COVERED* (Use separate sheet for additional child(ren). Below please list the Name, SS# and Relationship to Employee of any dependent(s).  Spouse _____ <small>Last Name First Name Middle Initial</small>	Social Security Number xxx-xx-xxxx	✓ SELECT COVERAGE	Relationship to Employee	Gender	Date of Birth xx/xx/xxxx
		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Dependent: _____ <small>Last Name First Name Middle Initial</small>		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Dependent: _____ <small>Last Name First Name Middle Initial</small>		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Dependent: _____ <small>Last Name First Name Middle Initial</small>		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Male <input type="checkbox"/> Female	

**You MUST Accept or Waive coverage by signing**



**O ACCEPT COVERAGE – Sign only if you are accepting the coverage offered**

**Statement of Application and Enrollment for Employer Groups**

By my authorized signature below, I elect TO ENROLL in my employer’s Health Benefit Plan offered by Five Points Benefit Plans, LLC.

- 1.) I authorize my employer to deduct from my earnings my share of the payment for health coverage, if applicable.
- 2.) I acknowledge that if I/we are qualified to receive a tax credit on the Health Insurance Exchange and enroll in my employer’s Health Benefit Plan then I/we may be disqualified from receiving a Tax Credit or subsidy on The Health Insurance Exchange, prior to the next open enrollment period.
- 3.) *I, on behalf of myself and my dependents(if any), understand that the following is acknowledged by my signature below that the plan benefits have been explained and I fully understand them.*
- 4.) *I further affirm that I have read completely and I understand the above, and if ANY of the above information changes, I will promptly notify my employer or Plan Administrator.*

**I consent that I have read and fully understand my Health Plan Coverage, Benefits and any limitations set forth in my plan policies and documents, including The Schedule of Benefits (SOB).**

**Employee Signature: X** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Printed Name:** \_\_\_\_\_ **Social Security #:** \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**WAIVE COVERAGE – Sign only if you are declining the coverage offered**

**NOTICE OF HIPAA RIGHTS:** *If you or dependent(s) decline coverage now under this Plan due to other coverage, you will be entitled to later enroll under this Plan only if the other coverage has been lost due to the other coverage being terminated. For example, your spouse may no longer be employed, or your COBRA continuation coverage has been exhausted. If the reason you lose other coverage is your failure to pay premiums, you will not be entitled to later enroll in the Plan. To protect your right to enroll later, you must notify your employer at this time in writing of the other coverage that you now have, including the source of other coverage. For example, you may have COBRA continuation coverage through a prior plan or your spouse. To enroll later in this Plan due to loss of other coverage, you (1) must request enrollment within 30 days after your other coverage ends, or (2) if you have a new dependent as a result of marriage, birth adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.*

*I, the undersigned participant, have been offered and have decided to decline coverage under my employer’s benefit plan as acknowledged by my signature below. I understand and voluntarily agree that by declining coverage I hereby waive coverage for myself and my dependents.*

**I decline to apply for this plan because I have:**

- |  |                          |  |                          |
|--|--------------------------|--|--------------------------|
| <b>A. Spousal coverage</b>                       | <input type="checkbox"/> | <b>F. Health Insurance Exchange coverage</b> | <input type="checkbox"/> |
| <b>B. Medicare coverage</b>                      | <input type="checkbox"/> | <b>G. Other Reason</b>                       | <input type="checkbox"/> |
| <b>C. Other group coverage</b>                   | <input type="checkbox"/> | <b>H. Medicaid/CHIPS</b>                     | <input type="checkbox"/> |
| <b>D. Individual health coverage</b>             | <input type="checkbox"/> | <b>I. Parental coverage</b>                  | <input type="checkbox"/> |
| <b>E. A subsidy on Health Insurance Exchange</b> | <input type="checkbox"/> | <b>J. Coverage too expensive</b>             | <input type="checkbox"/> |

**Employee Signature: X** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Printed Name:** \_\_\_\_\_ **Social Security #:** \_\_\_\_ - \_\_\_\_ - \_\_\_\_

