FIVEPOINTS
HEALTH BENEFIT PLANS

# Self-Funded Employer Group Plan

Company name_____

Plan Type _____

Plan Name: **Five Points Health Benefits, LLC**

Group No:_____Effective Date: ____/____/ 2021

Broker:_____

☐ **Open Enrollment** ☐ **New Enrollment**

☐ **Rehire Enrollment**

# *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 (ACA).***

***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 ***forYourself?***

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

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(ren) | 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).** | **Social Security Number xxx-xx-xxxx** | **√ SELECT COVERAGE** | **Relationship to Employee** | **Gender** | **Date of Birth xx/xx/xxxx** |
|---|---|---|---|---|---|
| **Spouse** _____ *Last Name First Name Middle Initial* | | ☐ Yes ☐ No | Spouse | ☐ Male ☐ Female | |
| **Dependent:** _____ *Last Name First Name Middle Initial* | | ☐ Yes ☐ No | | ☐ Male ☐ Female | |
| **Dependent:** _____ *Last Name First Name Middle Initial* | | ☐ Yes ☐ No | | ☐ Male ☐ Female | |
| **Dependent:** _____ *Last Name First Name Middle Initial* | | ☐ Yes ☐ No | | ☐ Male ☐ Female | |

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

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

### *Statement of Application and Medical Release*

**By my signature below, I WISH TO ENROLL in my employer's benefit plan.** Furthermore, I 1) **authorize my employer to deduct from my earnings my share of the payment for coverage, if applicable** (or reduce my pay if my employer has a Section 125 Plan); 2) authorize any medical provider, lawyer, or any other person or entity to release, use and disclose any and all of my medical information to claim administrator, Entrust, Inc., for the adjudication, processing, and/or payment of any and all of my medical claims for benefits; 3) understand that this authorization will expire when my coverage under my employer's benefit plan ends, which includes any coverage under COBRA; 4) affirm that I/we will abide by the provisions set forth in the SPD/Plan Document, which I authorize to be sent to me electronically, in addition to the Summary of Benefits & Coverage (provided to me on behalf of my applicable dependents unless a different address is specified for delivery), HIPAA Notice of Privacy Practices, and other important notices, such as Women's Health & Cancer Rights Act, Medicare Part D, COBRA, CHIPRA, and Patient Protection & Affordable Care Act (PPACA) and if I/we request a paper copy, I/we may receive such without cost to me; 5) understand that consent to receive such documents electronically may be revoked at any time by contacting Entrust; 6) certify that the information provided pertaining to this enrollment is true; and 7) authorize the release of individually identifiable and/or otherwise protected health information to affiliated and non-affiliated third parties to the extent allowed under HIPAA; and 8) acknowledge this plan does not provide comprehensive major medical coverage; and **9) acknowledge that if I/we am qualified to receive a tax credit on the Health Insurance Exchange and enroll in the my employer's benefit plan then I/we may be disqualified from receiving a tax credit or subsidy on a Health Insurance Exchange plan prior to the next open enrollment.** *I, on behalf of myself and my dependents,( if any), understand that our coverage may be reduced or terminated if we, individually or jointly, have made any false statements on enrollment, whether intentional or not, and further understand that by enrolling in my employer's benefit plan, such enrollment does not represent a guarantee of benefit payments, and does not form or in any way alter any contract between myself and my employer. I further affirm that I have read and understood the above and if ANY of the above information changes, I will promptly notify my employer by completing an Enrollment Change Form.*

***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:***

**A. Spousal coverage**
**B. Medicare coverage**
**C. Other group coverage**
**D. Individual health coverage**
**E. A subsidy on Health Insurance Exchange**
**F. Health Insurance Exchange coverage**
**G. Other Reason**
**H. Medicaid/CHIPS**
**J. Parental coverage**
**K. Coverage too expensive**

***Employee Signature: X*** _____ **Date:** ____/____/____

**Printed Name:** _____ **Social Security #:** ____-____-____