POINTS HEALTHCARE

Self-Funded Employer Group Plan

Company name: _____

Plan Type: Reference Based Pricing - (RBP)

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

Group No:_____Effective Date: ---/---/2025

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 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 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 | 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

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

Statement of Application and Enrollment for RBP 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 understood the above, and if ANY of the above information changes, I will promptly notify my employer or Plan Administrator.*

The RBP plan members are responsible for finding providers that will accept the RBP payments. There is no network or established set of required providers. Members can go to any provider or facilities they choose. However, the plan can identify providers and facilities who commonly accept the plan's reimbursement rates as payment in full, without requiring a network contract or provider agreement.

RBP open network may result in balance billing. We would mitigate and advocate on your behalf and resolve your claim dispute through mediation if it does.

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). Reference Base Pricing Limited Benefit Plan with Limitations and Deductibles.

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

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

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