

County Health Pool Enrollment Application and Change Form

Medical, Dental, Vision, and Life

Check all coverage that applies: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life			
Social Security/Member no. (must be completed by employee)	Health group no. (must be completed by employer)	Dental group no. (must be completed by employer)	Life group no. (must be completed by employer)
SECTION 1: REASON FOR COMPLETING APPLICATION			
<input type="checkbox"/> New enrollment <input type="checkbox"/> Address/phone change <input type="checkbox"/> Late entrant(s) <input type="checkbox"/> Reinstatement coverage <input type="checkbox"/> Termination <input type="checkbox"/> Beneficiary change <input type="checkbox"/> Add/change/remove family member(s) <input type="checkbox"/> Name change (previous name): _____ <input type="checkbox"/> Other: _____			
Qualifying event	Effective date of coverage (mm/dd/yyyy)	Date of qualifying event (mm/dd/yyyy)	
SECTION 2: BENEFITS AND COVERAGE DESIRED			
Ask your employer for coverage available.			
MEDICAL BENEFIT PLAN <input type="checkbox"/> PPO Plan A <input type="checkbox"/> HDHP 2000 <input type="checkbox"/> PPO Plan B 500 <input type="checkbox"/> HDHP 2500 <input type="checkbox"/> PPO Plan B 1000 <input type="checkbox"/> PPO Plan B 1500 <input type="checkbox"/> PPO Plan B 2000	MEDICAL COVERAGE FOR: <input type="checkbox"/> Employee <input type="checkbox"/> Employee & spouse or child <input type="checkbox"/> Family <input type="checkbox"/> Decline & complete Waiver of Insurance (section 10)	DENTAL BENEFIT PLAN <input type="checkbox"/> Dental Plan A <input type="checkbox"/> Dental Plan B	DENTAL COVERAGE FOR: <input type="checkbox"/> Employee <input type="checkbox"/> Employee & spouse or child <input type="checkbox"/> Family <input type="checkbox"/> Decline & complete Waiver of Insurance (section 10)
		VISION COVERAGE FOR: <input type="checkbox"/> Employee <input type="checkbox"/> Employee & spouse or child <input type="checkbox"/> Family <input type="checkbox"/> Decline & complete Waiver of Insurance (section 10)	
SECTION 3: EMPLOYEE AND FAMILY INFORMATION — Use a separate sheet if needed			
List yourself and all eligible family members who are applying for or do not want coverage. "Add" indicates the person is being added for coverage. "Change" indicates the person is changing coverage or personal information. "Remove" indicates the person should no longer be covered.			
<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	Employee last name	First name	M.I. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing street address for member correspondence		City	State ZIP code
Home phone no.	Hire date (mm/dd/yyyy)	Date full-time (mm/dd/yyyy)	Hours worked/week Earnings: \$ _____ Per: <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Year (complete only if Life/AD&D is based on earnings)
Work phone no.	Full company name	Position title	Employee email address
<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	Spouse/Domestic Partner (DP) last name	First name	M.I. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
If you and your spouse/DP have different last names, check the applicable box: <input type="checkbox"/> Spouse (Statutory Marriage - if special enrollment, attach marriage certificate) <input type="checkbox"/> Domestic Partnership (attach copy of Domestic Partnership Affidavit) <input type="checkbox"/> Common-law Marriage — AVAILABLE ONLY IN THE STATE OF COLORADO (Complete Section 8) <input type="checkbox"/> Civil Union (If Special Enrollment, attach Civil Union Registration)			Social Security no. (required)
<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	Dependent last name	First name	M.I. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Court-ordered Health Care Coverage (attach copy of court order) <input type="checkbox"/> Mentally/Physically Disabled Dependent (attach Mentally/Physically Disabled Dependent form)			Social Security no.
<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	Dependent last name	First name	M.I. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Court-ordered Health Care Coverage (attach copy of court order) <input type="checkbox"/> Mentally/Physically Disabled Dependent (attach Mentally/Physically Disabled Dependent form)			Social Security no.
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<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	Dependent last name	First name	M.I. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Court-ordered Health Care Coverage (attach copy of court order) <input type="checkbox"/> Mentally/Physically Disabled Dependent (attach Mentally/Physically Disabled Dependent form)			Social Security no.

1 A person named as Domestic Partner (DP) under a Certificate of Registered Domestic Partnership.

Required: Employee Social Security no.

SECTION 4: LIFE INSURANCE — Complete this section for Anthem Life Insurance Company coverage only. See your employer for available coverage.

Check applicable box: Group Term Life Dependent Life Supplemental Life employee amount: \$ _____ Supplemental Life spouse amount: \$ _____

Primary beneficiary last name	First name	M.I.	Social Security no.	Relationship
Primary beneficiary last name	First name	M.I.	Social Security no.	Relationship
Secondary beneficiary last name	First name	M.I.	Social Security no.	Relationship
Secondary beneficiary last name	First name	M.I.	Social Security no.	Relationship

SECTION 5: OTHER INSURANCE

Have you or any of your dependents had any other health coverage in the last six months, or currently have coverage other than the applied-for coverage? Yes No
 If Yes, please complete the section below for all covered members.

Member name (first, middle initial, last)	Type	Carrier	Begin (mm/dd/yyyy)	End (mm/dd/yyyy)
	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Prescription			
	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Prescription			
	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Prescription			
	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Prescription			

SECTION 6: MEDICARE COVERAGE — Complete if you, your spouse/DP or dependent child(ren) have Medicare coverage. Use a separate sheet if needed.

Member name (first, middle initial, last)	Part A effective date (mm/dd/yyyy)	Part B effective date (mm/dd/yyyy)	Reason for disability if under age 65	Medicare claim no.

If indicating MEDICARE as primary, please attach letter to that affect.

SECTION 7: WAIVER OF INSURANCE — Complete only if you do NOT want insurance coverage

Check all who do NOT want insurance coverage Employee Spouse/DP Child(ren)

I/We do NOT want to participate in the group insurance plan, at this time, for the following reason(s):

<input type="checkbox"/> I/We have other group health insurance. List those covered elsewhere.	<input type="checkbox"/> I/We have other individual health insurance. List those covered elsewhere.
<input type="checkbox"/> I/We have other group dental insurance. List those covered elsewhere.	<input type="checkbox"/> I/We have other group vision insurance. List those covered elsewhere.
<input type="checkbox"/> I have no other insurance coverage and I am not interested at this time.	<input type="checkbox"/> I am retired from military service. <input type="checkbox"/> I am a dependent of a uniformed or retired serviceman.

SIGNATURE — Required in Section 10

I hereby certify that I have been given the opportunity to participate in my Employer's Group Insurance Plan underwritten by the company(ies) indicated above. The plan has been explained to me and I decline to participate.

If I am declining enrollment for myself and/or my dependents (including my spouse/DP) because of other group or individual health insurance coverage, I may in the future be able to enroll myself and/or my dependents in this plan, provided that I request enrollment within 31 days after a qualifying event. In addition, if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

SECTION 8: COMMON-LAW AFFIDAVIT — SIGNATURES REQUIRED

- We the undersigned, being of lawful age, attest to the following facts:
- We have lived together continuously, in Colorado, as husband and wife from _____ to the present.
- We are free to contract a valid ceremonial marriage, i.e., are not already married to someone else.
- We hold ourselves out as husband and wife, consent to the marriage, cohabit and have the reputation in the community as being husband and wife.
- We understand that a common-law marriage, in the state of Colorado, is valid for all purposes, the same as a ceremonial marriage, and can only be terminated by death or divorce.

Employee signature

X

Spouse signature

X

Date

SECTION 9: IMPORTANT LEGAL INFORMATION

The following applies to health plans, dental, vision or life coverage offered through County Health Pool and/or Anthem Life Insurance Company, (collectively called "the Plans"):

It is unlawful to knowingly provide false, incomplete, or misleading facts or information for the purpose of defrauding or attempting to defraud the Plan. Penalties may include imprisonment, fines, denial of coverage/insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported.

I hereby authorize my employer, until this authorization is revoked by notice in writing, to deduct in advance each month from the earned or accrued wages due me, such amounts as may be necessary to pay the rates which are currently in effect or shall be in effect in the future for coverage for which I am applying.

I certify that I work at least 30 hours or at least 24 hours if my employer offers qualified part time coverage for the employer named on page one, if applying for coverage.

NOTICE OF PRE-EXISTING CONDITION EXCLUSION (Preexisting condition exclusion does not apply to policies that have been issued or renewed on or after 1/1/14.)

SECTION 10: SIGNATURE — Required

Please check one:

- I understand that the coverage I am applying for is subject to eligibility requirements. I acknowledge that I have read all areas of this application and certify that I agree to all matters covered herein.
- I am waiving insurance coverage as indicated in Section 7.

Employee signature

X

Date