2024 Employee Enrollment/Change Form

PLEASE USE BLACK OR BLUE INK ONLY
Mail Stop 100, PO Box 1121
Lewiston, ME 04243
Fax: (207) 402-3745

Instructions: Complete this form to elect, change or decline your healthcare coverage with Community Health Options. If you are electing or changing coverage, complete all sections of the form, except for section 3. If you are declining coverage, complete section 1, 2, and 3 only. Please submit this form to your Human Resources Department.

1. EMPLOYER INFORMATION

Must be completed for both Enrollment and Waiver

Employer Name	Employer Address	Group # (if known)

2. EMPLOYEE INFORMATION

Must be completed for both Enrollment and Waiver

Name (Last/First/Middle Initial)			Gender M / F	Race O American Indian or Alaska Native O Asian O Black or African American O Native Hawaiian or Pacific Islander O White
Date of Hire	Date of Birth	Social Security Number	Ethnicity O Hispanic or Latino O Not Hispanic or Latino	

Will you have other coverage while this policy is in effect? Y / N
Name of Other Coverage: Certificate or Policy #:

Physical Address		Apt./Suite #
City	State	ZIP Code
Mailing Address (if different from physical address)		Mailing Apt./Suite #
Mailing City	Mailing State	Mailing ZIP Code
Email address		Phone ( ) - O Home O Mobile O Work

3. DECLINATION/WAIVER OF COVERAGE

To be completed if medical coverage is declined or refused by an eligible employee

Reason for declining coverage:	
O Covered through Spouse/Domestic Partner's employer O Covered through another employer	O Other coverage (includes Individual & Government coverage) O Choose not to have coverage at this time O Other reasons

I acknowledge I have been given the right to apply for this coverage; however, I am electing not to enroll. By declining this coverage, I acknowledge that I and/or my dependents may have to wait until the plan's next anniversary date to be enrolled for group coverage.

Please sign here ONLY IF YOU ARE DECLINING coverage for yourself and your dependents, if any
Employee Signature_____ Date____/_____/_____

COMMUNITY Health Options®

4. ENROLLMENT INFORMATION

Must be completed if employee is taking coverage

Enrollment reason	Special Event (Required for Life Event)	Coverage Change (Required for Life Event)
O Open Enrollment – New Enrollment	O Birth or adoption	O Add Spouse/Domestic Partner
O Open Enrollment – Renewal	O Court Order	O Remove Spouse/Domestic Partner
O New Hire	O Marriage	O Add Dependent
O Rehire/Reinstatement	O Divorce, separation, or annulment	O Remove Dependent
O COBRA Continuation	O Death	O Name Change
O Life Event (Complete Special Event and Coverage Change Sections) Date of Event:___/___/___	O Employment or benefit eligibility status change	O Address Change
	O Medicare/Medicaid eligibility event	O Other Change: _____
* Requested Effective Date: _____/__/_____	O Losing access to other coverage	
	O Termination of Employment	
	O Other: _____	

*Coverage must begin on the first of the month and end on the last day of the month, except for birth, adoption, or death.

5. FAMILY MEMBER INFORMATION

Must be completed for eligible family members you wish to cover, delete or change

Attach additional sheet if more than 2 dependents are covered

Spouse / Domestic Partner

Name (Last, First, M.I.)			**Gender** M / F	Race
Date of Hire	**Date of Birth**	**Social Security Number**	Ethnicity O Hispanic or Latino O Not Hispanic or Latino	O American Indian or Alaska Native O Asian O Black or African American O Native Hawaiian or Pacific Islander O White

Will this person have other coverage while this policy is in effect? Y / N

Name of Other Coverage: Certificate or Policy #:

Dependent

Name (Last, First, M.I.)			**Gender** M / F	Race
Date of Hire	**Date of Birth**	**Social Security Number**	Ethnicity O Hispanic or Latino O Not Hispanic or Latino	O American Indian or Alaska Native O Asian O Black or African American O Native Hawaiian or Pacific Islander O White

Will this person have other coverage while this policy is in effect? Y / N

Name of Other Coverage: Certificate or Policy #:

Dependent

Name (Last, First, M.I.)			**Gender** M / F	Race
Date of Hire	**Date of Birth**	**Social Security Number**	Ethnicity O Hispanic or Latino O Not Hispanic or Latino	O American Indian or Alaska Native O Asian O Black or African American O Native Hawaiian or Pacific Islander O White

Will this person have other coverage while this policy is in effect? Y / N

Name of Other Coverage: Certificate or Policy #:

Children may be covered as dependents by their parents up until age 26. When a dependent turns 26, coverage may continue until the end of the month. If a dependent listed above is disabled and age 26 or older, please submit supporting documentation. Spouse, domestic partner and dependent eligibility is subject to your employer's eligibility guidelines.

COMMUNITY Health Options®

6. MEDICAL COVERAGE

Select one plan
Must be completed if Employee is taking coverage

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7. LEGAL ACKNOWLEDGEMENTS AND SIGNATURE

Must be completed if Employee is taking coverage

I understand that:

- I will receive notice by mail of my membership status with Community Health Options once Community Health Options has received and processed my application. Upon notification of membership, I will receive a Member ID Card, online access to the applicable Member Benefit Agreement and any other necessary documents relating to my Community Health Options membership and coverage.
- If I or any covered family member is insured by more than one health contract, coordination of benefits will apply. Coordination of benefits ensures that the total benefits received from all contracts do not exceed the actual cost of covered services.
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  I am requesting coverage for myself and all dependents listed on this application. All statements and answers I have given are true and complete. I understand any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact found in this application may result in denial of benefits, rescission, or cancellation of my coverage(s). I understand all benefits are subject to the conditions stated in the Member Benefits Agreement.

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

Employee Printed Name: _____

Employee Signature: _____ Date: _____