Promise℠ Health Plan

HEALTHCARE ENROLLMENT FORM

Subscriber Name	Subscriber SSN	Date of Birth	Gender

Address	City	State	Zip Code

Employer Name	Employee Date of Hire	Date Eligible for Benefits

Reason for Enrollment (Must provide proof of dependent status for all enrollments)

☐ Open Enrollment ☐ Initial Enrollment

☐ Enrollment change due to (please check appropriate box below and provide verification as indicated):

- ☐ Marriage (certificate)
- ☐ Divorce (court order)
- ☐ Court ordered coverage (court order)
- ☐ Other:
- ☐ Birth of a child (birth certificate)
- ☐ No longer meets eligibility requirements
- ☐ Adoption or placement for adoption (court order)
- ☐ Loss of other health coverage (attach proof of loss of coverage)

Benefit Options and Coverage Selection

Medical	Plan Option Selection:

☐ Decline Coverage - I wish to decline medical coverage.

Savings & Spending Account Elections

I elect to participate in the following reimbursement account(s) and authorize the amount(s) below to be deducted from each of my paychecks:

Health Savings Account: *The annual contribution amount cannot exceed $4,150 for individuals and $8,300 for families.*

Amount/pay period: $ _____ X # of pay periods_____ = _____Total Annual Election Amount

☐ I wish to decline participation in a health savings account.

Flexible Spending Account: *The annual maximum cannot exceed $3,200.*

Amount/pay period: $ _____ X # of pay periods_____ = _____Total Annual Election Amount

☐ I wish to decline participation in a health care reimbursement account.

Dependent Care Reimbursement Account: *The annual maximum cannot exceed $5,000.*

Amount/pay period: $ _____ X # of pay periods_____ = _____Total Annual Election Amount

☐ I wish to decline participation in a dependent care reimbursement account.

Deduction Authorization

I authorize my employer to reduce my earnings for the plan year beginning , by the amount(s) indicated above. Funds deposited into my Health Care and/or Dependent Care Flexible Spending Account(s) will be available to pay for eligible expenses during the plan year. I understand that I cannot change my contributions during the plan year. The plan year begins January 1 and ends December 31. I will have until March 31 of the following year to submit expenses incurred during the plan year. I understand that Internal Revenue Service rules require that I forfeit unused account balances.

Signature: Date:

Add Dependent Spouse

Last Name	First Name	M/I	Gender M/F	SSN (required)	DOB	Disabled Y/N

Does your Spouse have access to other medical coverage through his or her employer? Please circle one: Yes No

Is your spouse covered under another medical plan? (Circle one) Yes / No If yes, Name of Carrier:

Add Dependent Child

Last Name	First Name	M/I	Gender M/F

SSN (required)	DOB	Relationship	FT Student Over 18? Y/N	Foster/Step Child? Y/N	Disabled? Y/N

Does this dependent have access to other medical coverage? (Circle one) Yes / No If yes, Name of Carrier:

Is this dependent covered under another medical plan? (Circle one) Yes / No If yes, Name of Carrier:

Add Dependent Child

Last Name	First Name	M/I	Gender M/F

SSN (required)	DOB	Relationship	FT Student Over 18? Y/N	Foster/Step Child? Y/N	Disabled? Y/N

Does this dependent have access to other medical coverage? (Circle one) Yes / No If yes, Name of Carrier:

Is this dependent covered under another medical plan? (Circle one) Yes / No If yes, Name of Carrier:

Add Dependent Child

Last Name	First Name	M/I	Gender M/F

SSN (required)	DOB	Relationship	FT Student Over 18? Y/N	Foster/Step Child? Y/N	Disabled? Y/N

Does this dependent have access to other medical coverage? (Circle one) Yes / No If yes, Name of Carrier:

Is this dependent covered under another medical plan? (Circle one) Yes / No If yes, Name of Carrier:

Employee Signature (Read and Sign Below)

I understand and agree with the following statements:

- My dependents are not eligible for any coverage for which I am not covered.
- I have read and understand my rights and Special Enrollment which are included with this enrollment form.
- My dependents, including step and foster children and those over the maximum age, are eligible for coverage based on plan provisions.
- If I decline the benefit options offered or do not complete and return this enrollment form I and/or my dependents may not enroll until the next Open Enrollment Period unless I experience a qualified change in family status. Changes in election due to a qualifying change in the family status must be made no later than 31 days after the date of the qualifying change in the status.
- The plan offered by my employer does not coordinate benefits as a secondary plan except as required by law.
- I authorize my employer to deduct the applicable contributions (as indicated above) from my pay.
- Any person who, with intent to defraud or knowing that he or she is facilitating a fraud by submitting an application, enrollment form, or filing a claim containing a false or deceptive statement may be guilty of fraud.
- If I am requesting to cancel coverage because of Exchange enrollment, I certify that (and any related individuals whose coverage is being cancelled) have enrolled or intend to enroll for new Exchange coverage that is effective no later than the day after the date on which I wish to revoke the medical coverage.

I declare that the information I have completed on this enrollment form is complete and true.

Signature: Date: