TheHealthPlan
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Self-Funded Group Enrollment/Change Form

Section A: General Information (Please Print)

Group Name:	Location:	Date of Hire:	Effective Date:
Louisiana Assessors Association	(Parish)		

Section B: Coverage Selection

Medical:	Group #: 0180951100	☐ Decline Coverage	☐ Employee	☐ Employee + Spouse	☐ Employee + Child	☐ Employee + Children	☐ Employee + Family
Dental:	Group #: 0180951100	☐ Decline Coverage	☐ Employee	☐ Employee + Spouse	☐ Employee + Child	☐ Employee + Children	☐ Employee + Family
Vision:	Group #: _____	☐ Decline Coverage	☐ Employee	☐ Employee + Spouse	☐ Employee + Child	☐ Employee + Children	☐ Employee + Family
Other:	Group #: _____	☐ Decline Coverage	☐ Employee	☐ Employee + Spouse	☐ Employee + Child	☐ Employee + Children	☐ Employee + Family

Section C: Reason for Completion

☐ New Enrollee	☐ Add Dependent	☐ Changes	☐ COBRA	☐ Cancel Employee	☐ Cancel Dependent
☐ New Hire/Rehire	☐ Birth	☐ Address Change	(Attach copy of COBRA election form)	☐ Terminated	☐ Divorce
☐ Recall	☐ Adoption	☐ Name Change		☐ Retired	☐ Deceased
☐ Part-time to Full-time	☐ Open Enrollment	☐ Group Transfer	Start Date: _____	☐ Involuntary Layoff	☐ Age 26
☐ Marriage	☐ Other: _____	☐ Other: _____	End Date: _____	☐ Other Coverage	☐ Other: _____
☐ Qualifying Event/ Special Enrollment – Documentation Required				☐ Open Enrollment	
Event Date: _____				Event Date: _____	
				Cancel Date: ☐ Date of Event ☐ End of Month	

Section D: Employee Information (REQUIRED)

Social Security Number	Last Name	First Name	MI	Gender ☐ M ☐ F	Date of Birth (MM/DD/YY)

Mailing Address	City	State	Zip	County

Phone	Email	Other Insurance? ☐ Yes ☐ No *If Yes, complete Section F*	Have you ever been enrolled with The Health Plan before? ☐ Yes ☐ No

Section E: Dependent Information

Action	Relationship (ex. Spouse)	Last Name	First Name	MI	DOB	Gender	Other Ins. Coverage*	SS#
☐ Add ☐ Delete						☐ M ☐ F	☐ Y ☐ N	
☐ Add ☐ Delete						☐ M ☐ F	☐ Y ☐ N	
☐ Add ☐ Delete						☐ M ☐ F	☐ Y ☐ N	
☐ Add ☐ Delete						☐ M ☐ F	☐ Y ☐ N	
☐ Add ☐ Delete						☐ M ☐ F	☐ Y ☐ N	

If Yes for Other Insurance Coverage, complete Section F.

Section E: Dependent Information (continued)

Action ☐ Add ☐ Delete	Relationship (ex. Spouse)	Last Name	First Name	MI	DOB	Gender ☐ M ☐ F	Other Ins. Coverage* ☐ Y ☐ N	SS#
☐ Add ☐ Delete						☐ M ☐ F	☐ Y ☐ N	

If Yes for Other Insurance Coverage, complete Section F.

Section F: Other Health Insurance Coverage

*If you checked "Yes" to other coverage in Section D or E, please provide the following information:

Name	Policyholder's Name	Policy Number	Name of Insurance Carrier	Insurance Carrier's Phone No.

Medicare Information

Do you or any of your dependents have Medicare coverage (or expected to receive within 60 days of effective date)? ☐ Yes ☐ No

If "Yes", please provide who is covered, Medicare ID, Part A and Part B effective dates. Also, if applicable provide Part D effective date.

Name	Medicare ID	Part A Effective Date	Part B Effective Date	Part D Effective Date

ELECTION OF HEALTH CARE COVERAGE UNDER THE EMPLOYER FUNDED PLAN ADMINISTERED BY THE HEALTH PLAN, CLAIMS SUPERVISOR

I hereby elect coverage for myself, and for those eligible members of my family listed on this enrollment application, for the benefits offered through the Employer Funded Plan ("Plan"). Eligible family members may include my spouse, children as defined within the Employer Funded Plan Participant Handbook, and unmarried children of any age if prior to reaching age 26, they are incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon me for support and maintenance. All persons listed on this application, including myself, shall be referred to as the "family unit."

I agree for myself and other members of my family unit to be bound by the benefits, deductibles, copayments, exclusions, limitations, and other terms of the Plan, as is or as amended, as defined within the benefit provisions of the Plan. Furthermore, I agree to provide to the Plan any legal or other documentation to verify eligibility (i.e. marriage license, birth certificate, driver license, voter registration).

I understand on behalf of myself and eligible dependents, that certain information may be disclosed to other entities. (This disclosure is further explained in your Employer's Privacy Notice).

If I am required to contribute a part of the premium, I hereby agree to pay, in advance, the amount due to the Employer.

I hereby state that all information furnished by me here is true and complete to the best of my knowledge and shall be deemed representations.

Insurance Fraud Warning: "Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements is guilty of insurance fraud."

Employee Signature: Date:

Employer/Broker Signature: Date Submitted: