

1110 Main St., Wheeling, WV 26003 enrollment@healthplan.org
PH: 1.800.624.6961 / FAX: 1.740.699.6163

## Self-Funded Group Enrollment/Change Form

## Section A: General Information (Please Print)

Color A. Oction at Illionia						76600+	7
Group Name: Louisiana Assessors Association	ors Association	(Parish)			מ מ		מואס ביים
Section B: Coverage Selection	on						
Medical: Group #: 0180951100	Decline Coverage	□ Employee	☐ Employee + Spouse ☐	☐ Employee + Child	nild □ Employee + Children	1	□ Employee + Family
Dental: Group #: 0180951100	□ Decline Coverage □ Employee		☐ Employee + Spouse ☐	☐ Employee + Child		+ Children	☐ Employee + Children ☐ Employee + Family
Vision: Group #:	□ Decline Coverage	□ Employee [	☐ Employee + Spouse ☐	□ Employee + Child	hild ☐ Employee + Children		□ Employee + Family
Other: Group #:	□ Decline Coverage □ Employee		☐ Employee + Spouse ☐	Employee + Child		+ Children	☐ Employee + Children ☐ Employee + Family
Section C: Reason for Completion	letion						
□ New Enrollee □ Add De	☐ Add Dependent ☐ Changes	inges	□ COBRA	□ Ca	□ Cancel Employee	□ Cano	□ Cancel Dependent
hire		☐ Address Change	(Attach copy of COBRA		□ Terminated	□ Divorce	Ce
□ Recall □ Adoption		□ Name Change	election form)	□ Retired	fired	☐ Deceased	ased
□ Part-time to Full-time □ Open I	□ Open Enrollment □ Gro	☐ Group Transfer	sidri Dare:	- Inv	□ Involuntary Layoff	□ Age 26	26
☐ Marriage ☐ Other:	Other:	er:	End Date:	O#	□ Other Coverage	□ Other:	
<ul> <li>Qualifying Event/ Special Enrollment –</li> <li>Documentation Required</li> </ul>	<b>↑</b>			□ Op Event	□ Open Enrollment  Event Date:		
Section D: Employee Information (REQUIRED)	ation (REQUIRED)			C	Caricer Dale: L Da		ם מי אסוווי
Social Security Number	Last Name		First Name		M Ge	Gender Date	Date of Birth (MM/DD/YY)
Mailing Address			City	Sto	State Zip	County	
Phone Email	Ω:		Othe If Yes	Other Insurance? ☐ Yes [ If Yes, complete Section F	NO NO	Have you ever been enrolled value Health Plan before?  The Health Plan before?	en enrolled with efore? 🗆 Yes 🗀 No
Section E: Dependent Information	nation						
Relationship Action (ex. Spouse)	Last Name		First Name	MI DOB	Gender Co	Other Ins. Coverage*	SS#
□ Add □ Delete					_	O Y O N	
□ Add □ Delete					_ M _ F _ C	_ Y _ N	
□ Add □ Delete						JY UN	
□ Add □ Delete						]   N	
□ Add □ Delete				*# <b>\Q</b> 2 <b>f</b> 0	*If Yes for Other Insurance	Y U N	Complete section F*
				T YOU TO	TO THE INCIDENCE		

Section E: Depo	endent Infor	Section E: Dependent Information (continued)						
Action	Relationship (ex. Spouse)	Last Name	First Name	≦	DOB	Gender	Other Ins. Coverage*	SS#
□ Add □ Delete						□M □F	OY ON	
□ Add □ Delete						□M □F	OY ON	
1 1					*If Yes for C	Other Insuran	ce Coverage	*If Yes for Other Insurance Coverage, complete Section F
Section F: Othe	r Health Insu	Section F: Other Health Insurance Coverage						
*If you checked "Ye Name	s" to other cove	overage in Section D or E, please policyholder's Name	*If you checked "Yes" to other coverage in Section D or E, please provide the following information:    Name   Policyholder's Name   Policy Number   Policy Nu	Name	: Name of Insurance Carrier	Carrier	Insurance	Insurance Carrier's Phone No.
Do you or any of your deper	our dependents	have Medicare coverage (or ex	Do you or any of your dependents have Medicare coverage (or expected to receive within 60 days of effective date)? □ Yes	s of ef	fective date	1 1	□ No	
If "Yes", please prov Name	vide who is cove  M	If "Yes", please provide who is covered, Medicare ID, Part A and Part B effective dates.  Name   Medicare ID   Part A Effective Date	art B effective dates. Also, it app Part A Effective Date	Part B	Also, it applicable provide Part D effective date.    Part B Effective Date	te	Part D Effe	Part D Effective Date
ELECTION OF HE	ALTH CARE C	OVERAGE UNDER THE EM	ELECTION OF HEALTH CARE COVERAGE UNDER THE EMPLOYER FUNDED PLAN ADMI		TERED BY T	HE HEALTH	H PLAN, CI	NISTERED BY THE HEALTH PLAN, CLAIMS SUPERVISO
I hereby elect cover on this enrollment ap	age for myself, an oplication, for the	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"). Fliaible family members may include my spause, children as defined		behalt	of myself and her entities. (	d eligible dep This disclosure	endents, that is further exp	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)
within the Employer I	Funded Plan Part aching age 26, the or physical band	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 handican and chiefly dependent upon me for	children of If I am required to contribute a part of the premium, I hereby agree to pay, in advance, the amount due to the Employer.	nount	ribute a part due to the Er	of the premiunployer.	ım, I hereby a	gree to pay, in
support and maintenance. All per be referred to as the "family unit."	"family unit."	support and maintenance. All persons listed on this application, including myself, shall be referred to as the "family unit."		at all it ledge	nformation fu and shall be	nished by me deemed repr	e here is true or esentations.	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.
l agree for myself an deductibles, copayr as amended, as def l agree to provide to	d other members nents, exclusions, ined within the ba the Plan any leg	Lagree 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, Lagree to provide to the Plan any legal or other documentation to verify eligibility	enefits, as is or bility	Warni a fraud or ded	ng: "Any pers d against an ii septive stater	on who, with nsurer, submit nents is guilty	intent to defres an application of insurance	<b>Insurance Fraud Warning:</b> "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:	14		Date:				18	
Employer/Broker Signature:	gnature:		Date Submitted:					