The HealthPlan

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Enrollment/Change Form

Section A: General Information		
Employer Name	Group #	Group Location

Section B: Employee Information				
Employee SS# or THP #	Employee Last Name	Employee First Name		MI
Mailing Address	City	State	Zip	Phone

Section C: Employee Additions/Changes

	Date of Event	Effective Date

- ☐ New hire
- ☐ Rehire
- ☐ Recall
- ☐ Open enrollment
- ☐ Part time to full time
- ☐ Address change

- ☐ Name change to _____
- ☐ Transfer to new group # _____
- ☐ Qualifying Event – Special Enrollment**
- ☐ Qualifying Event - Section 125**

**Loss of coverage requires COCC from previous carrier

- ☐ Federal COBRA Election (attach copy signed election form)
  Effective date: _____
  End date: _____
- ☐ State Continuation (Mini-COBRA)
  Effective date: _____
  End date: _____

Section D. Employee Termination

		Date of Event	Effective Date
☐ Term Employment (Voluntary) ☐ Term Employment (Involuntary) ☐ Termed COBRA	☐ Open Enrollment Drop ☐ Personal ☐ Layoff	☐ Deceased ☐ Retired ☐ Coverage through spouse	☐ Medicare Eligible ☐ Moved out of THP Service area ☐ Exhausted FMLA, Sick Leave or Workers' Comp

Section E: Dependent Information…Additions/Terminations

				Date of Event		Effective Date	
Dependent Last Name	Dependent First Name	MI	DOB	M/F	Relationship	PCP (if required)	SS#

- ☐ Marriage
- ☐ Open enrollment
- ☐ Elected COBRA
- ☐ Newborn
- ☐ Adoption*

- ☐ Qualified child support order*

*Legal document required

- ☐ Qualifying Event – loss of coverage**
- ☐ Qualified Event - Section 125**

**Loss of coverage requires COCC from previous carrier

- ☐ Divorce
- ☐ Medicare eligible
- ☐ Over age limit
- ☐ Deceased
- ☐ Other coverage

- ☐ Open enrollment drop
- ☐ Moved out of THP service area

Signature	Date Submitted

SUBSCRIBER/EMPLOYEE

To be eligible to enroll as a subscriber, the employee must be a full-time employee of the group and meet the eligibility requirements as defined by the employer group and agreed to by THP. The person must also be entitled to participate in the hospital and medical benefits arranged by the group, or entitled to coverage under COBRA.

DEPENDENTS

SPOUSE: The employee's legally married spouse may be included on the coverage. An enrollment change form must be completed and received at THP within 31 days from the date of marriage for a newly eligible, dependent spouse. If the spouse has a different last name from the employee, legal documentation (i.e., copy of the marriage certificate) is required to confirm the marital relationship. Coverage will not be activated unless documentation is attached to the enrollment form. A divorced or common law spouse is excluded from eligibility (legally separated/separate maintenance if required by group). Coverage will end for a divorced spouse on the divorce date (unless specified differently by the employer and agreed to by THP).

DEPENDENT CHILDREN: Natural child, adopted child, step-child, newborn child or must have legal guardianship or custody as defined in the group contract. If legal guardian or custodian, both natural parents must be physically or mentally handicapped to the point where they cannot take care of the child.

Important note: When children are added with last names different than the subscriber, legal documentation is required to confirm the parental relationship to the subscriber or the subscriber's legally married spouse (i.e., birth certificates, copies of divorce papers showing the non-custodial parent's responsibility to provide health coverage, court documentation showing proof of paternity). **Coverage will not be activated unless documentation is attached to the enrollment form.**

Newborn children: an enrollment change form must be completed and received at THP **within 31 days from the date of birth.**

A handicapped child is a qualified dependent child as stated in the IRS Publication 501, Section 152 that is permanently and totally disabled if both of the following apply:

He or she cannot engage in any substantial gainful activity because of a physical or mental condition.

A doctor determines the condition has lasted or can be expected to last continuously for at least a year or can lead to death.

FEDERAL COBRA

Please write the COBRA event, beginning and end dates on the enrollment change form. If the family status changes from active to COBRA coverage, a new enrollment form must be completed. AS A REMINDER, **YOU MUST ATTACH A COPY OF THE SIGNED COBRA ELECTION FORM TO THE CHANGE FORM. Coverage will not be activated unless a copy of the signed election form is attached.**

Ohio State Continuation (Mini-COBRA/less than 20 employees)

Please write the COBRA event beginning and end dates on the enrollment change form. If the family status changes from active to COBRA coverage, a new enrollment form must be completed.

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.

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