Hometown Health

# Enrollment / Change Form

**Hometown Health Use Only**

G#
M#
L
F,M

## Human Resources Only

Employer_____ Group#_____ Effective Date_____
Employee's Weekly Hours_____ Employee's Date of Hire_____ Employer Signature_____

## Employee Information

| Name (Last) | (First) | (M.I.) | Social Security Number |
|---|---|---|---|
| | | | ___-___-____ |

| Mailing Address (Street or P.O. Box) | City | State | Zip Code | County |
|---|---|---|---|---|
| | | | | |

| Physical Address | City | State | Zip Code | County |
|---|---|---|---|---|
| | | | | |

| Date of Birth | Marital Status | Occupation | Home Phone | Work Phone |
|---|---|---|---|---|
| ____/____/____ | Married ❑ Single ❑ Divorced ❑ Widowed ❑ | | (  )____-____ | (  )____-____ |

## Plan Elected

❑ HMO Plan Elected_____ ❑ PPO Plan Elected_____ ❑ PPO w/HSA* Plan Elected_____ ❑ HMO w/HSA* Plan Elected_____

*Street Address only, no P.O. Boxes

## Other Medical Coverage:

Do you or any of your Dependents listed below have Medical/Health Insurance (Including Medicare/Medicaid)?

❑ Yes ❑ No

If yes, please provide copy of insurance card (front & back)

## Contract Termination Only

Completion of this section will terminate coverage for subscriber and all dependents.

❑ Left Company ❑ Moved ❑ Dissatisfied
❑ Deceased ❑ Ineligible ❑ Other_____

## Reason for Change

❑ New Hire
❑ Name
❑ Annual Election
❑ Rehire
❑ Other_____
❑ COBRA (18-29-36)
❑ PT/FT
❑ Reinstatement
❑ Waive Coverage
❑ Retiree
❑ Transfer
❑ Address

Plan Change: From:_____To:_____

## Add/Delete Dependent

*❑ Marriage *❑Divorce
*❑Birth/Adoption *❑Other
*❑Loss of Dependent Status *❑Court Ordered/Legal Guardianship
*❑ Loss of Insurance *❑Deceased

* Attach legal documentation as proof of event.

## Member Information – Complete with new or change information

| Action | *(Last) (First) (M.I.) | Social Security Number | Birth Date Mo./Day/Yr. | Sex M/F | Reside with Emp.? Y/N | **PRIMARY CARE PHYSICIAN (if required) |
|---|---|---|---|---|---|---|
| Add ❑ Change ❑ Delete ❑ | Employee: | | | | - | |
| | Email Address: | | | | | |
| Add ❑ Change ❑ Delete ❑ | Spouse | | | | | |
| | Email Address | | | | | |
| Add ❑ Change ❑ Delete ❑ | Dependent Child (Relationship) | | | | | |
| | This Shaded Space For Hometown Health Use Only | | | | | |
| Add ❑ Change ❑ Delete ❑ | Dependent Child (Relationship) | | | | | |
| | This Shaded Space For Hometown Health Use Only | | | | | |
| Add ❑ Change ❑ Delete ❑ | Dependent Child (Relationship) | | | | | |
| | This Shaded Space For Hometown Health Use Only | | | | | |
| Add ❑ Change ❑ Delete ❑ | Dependent Child (Relationship) | | | | | |
| | This Shaded Space For Hometown Health Use Only | | | | | |

** It is member's responsibility to verify physician availability in their area.

Revised Mar. 2015

ACKNOWLEDGEMENT OF TERMS Employee Signature X_____Date_____
(SEE REVERSE SIDE)

## Acknowledgement of Terms

I understand and agree that, with the exception of emergency procedures, all services must be performed by a Hometown Health participating provider, or authorized in advance by Hometown Health, to be considered for payment at the in-network rate. Additional requirements may apply. See the appropriate plan documents for details.

I understand that I am responsible for paying any required deductibles, copayments, and coinsurance directly to the providers of healthcare at the time of service.

I agree to be bound by all terms of the plan under which I am applying for coverage for as long as I am covered under the plan.

I certify that, to the best of my knowledge, the information shown on the front of this form is correct.

I have read and understand the terms of this application.

My signature on the front of this form constitutes acceptance of the terms listed above.

Key to plan types:
HMO: Health Maintenance Organization
PPO: Preferred Provider Organization
TPA: Third Party Administrator for self-funded plan
HSA: Health Savings Account

## Statement of Accountability

**To be completed only when the applicant cannot complete the application**
***Note*: Translator must be 18 years or older to translate the application on behalf of the applicant**

I, _____, personally read and completed this Individual Application for the applicant named below because:

❑ Agent assisted application ❑ Applicant does not read English ❑ Applicant does not speak English
❑ Applicant does not write English ❑ Other (explain)_____

I translated the contents of this form and to the best of my knowledge obtained and listed all the requested personal and medical history disclosed by the:

❑ Applicant ❑ Or by:_____

**I also translated and fully explained the "Application Understandings, Conditions and Agreement," and "Payment Method."**

_____
Translator Signature (Required) Date (Required)

**I confirm that the application was translated on my behalf.**

_____
Applicant Signature (Required) Date (Required)

**Language interpreted (e.g. Spanish):**