Community Health Options™
Employee Enrollment/Change Form
PLEASE USE BLACK OR BLUE INK ONLY

Mail Stop 100, PO Box 1121
Lewiston, ME 04243
Fax: (207) 402-3745

The information in this application must be submitted electronically, so please return this paper application to either your Employer or Broker for processing.

If you have any questions, please contact your Benefits Administrator or call Community Health Options at (207) 402-3353. If you are interested in joining Community Health Options, please complete Sections 1-5 and 7. If you are declining coverage, please fill out sections 1, 2 and 6.

1. Employer Information

Employer Name *	Employer Address *	Group # (if known)

2. Employee Information

Name (Last/First/Middle Initial) *		Date of Hire *:
Enrollment reason*	**Special Event** *(Required if Enrollment Reason is Life Event)*	**Coverage Change** *(Required if Enrollment Reason is Life Event)*
☐Open Enrollment – New Enrollment ☐Open Enrollment – Renewal ☐New Hire ☐Rehire/Reinstatement ☐COBRA Continuation ☐Decline Coverage ☐Life Event *(Complete Special Event and Coverage Change Sections)* Date of Event: ____/ ____/_____	☐Birth or adoption ☐Court Order ☐Marriage ☐Divorce, separation, or annulment ☐Death ☐Employment or benefit eligibility status change ☐Medicare/Medicaid eligibility event ☐Losing access to other coverage ☐Termination of Employment ☐Other _____	☐Cancel Coverage ☐Add Spouse/Domestic Partner ☐Remove Spouse/Domestic Partner ☐Add Dependent ☐Remove Dependent **Update Personal Data** ☐Name Change ☐Address Change ☐Other Change_____

Requested Effective Date: _____/_____/_____	**Coverage must begin on the first of the month and end on the last day of the month, except for birth, adoption, or death. **

Physical Address *		Apt./Suite #	
City*		State*	Zip Code*
Telephone*: Home:	Work:	Marital Status ☐ Single ☐ Married	
Mailing Address (if different from physical address)			
Email address:			

Items marked with an * are a required field.

33653ME0118B

3. Employee and Family Member Information*

Please complete for eligible family members you wish to cover, delete, change, or for the employee declining.

NAME(S) OF PERSON(S) (Last, First, MI)	Relationship to you	Date of Birth (mm/dd/yy)	Gender	Social Security Number (SSN) xxx-xx-xxxx	Has this person been a smoker within the last 6 months?	Will this person have other health insurance while this coverage is in effect?	Name of Other Coverage	Certificate /policy #
	SELF		☐F ☐M		☐Y ☐N	☐Y ☐N		
	SPOUSE/ DOMESTIC PARTNER		☐F ☐M		☐Y ☐N	☐Y ☐N		
	DEPENDENT		☐F ☐M		☐Y ☐N	☐Y ☐N		
	DEPENDENT		☐F ☐M		☐Y ☐N	☐Y ☐N		
	DEPENDENT		☐F ☐M		☐Y ☐N	☐Y ☐N		

Children may be covered as Dependents by their parents up until age 26. When a Dependent turns 26, coverage may continue until the end of the month. If a Dependent listed above is a Disabled Dependent age 26 or older, please submit supporting documentation. Spouse/Domestic Partner and Dependent eligibility is subject to your employer's eligibility guidelines.

4. Primary Care Provider (PCP) Assignment*

Selecting a Primary Care Provider (PCP) is required under all Community Health Options plans. You have the right to designate any PCP who participates in our network and who is available to accept you and/or your family members. PCPs are typically Family Practice, General Practice or Internal Medicine Doctors, Nurse Practitioners, or Certified Nurses/Midwives. For children, you may designate a pediatrician as your PCP. Our Provider Directory http://www.healthoptions.org/search-provider *includes a list of Providers and information about providers who are part of our network.*

Please complete information for assignment of Network Primary Care Providers for covered family members. If you do not assign a PCP, Community Health Options will assign one to you. You have the right to change your PCP at any time. PCP changes can be submitted through your Member portal or by contacting Member Services at (855) 624-6463.

Member Name (Last, First, MI)	Primary Care Provider Name (First, Last)	Practice Location

Items marked with an * are a required field.

5. Medical Coverage* (Select one plan offered by your Employer)

☐ **Community Progress (Bronze)** $7,750 Individual/$15,500 Family Deductible *Includes Pediatric Dental*	☐ **Community Select (Silver)** $4,200 Individual/$8,400 Family Deductible *Includes Pediatric Dental, Chronic Illness Support Program*
☐ **Community Access HSA (Bronze)** $6,650 Individual/$13,300 Family Deductible *Includes Pediatric Dental, Preventive Drug List*	☐ **Community Accord (Silver)** $3,700 Individual/$7,400 Family Deductible *Includes Pediatric Dental, Chronic Illness Support Program*
☐ **Community Option HSA (Bronze)** $5,700 Individual/$11,400 Family Deductible *Includes Pediatric Dental, Preventive Drug List*	☐ **Community Assure (Silver)** $3,200 Individual/$6,400 Family Deductible *Includes Pediatric Dental, Chronic Illness Support Program*
☐ **Community Basic HSA (Bronze)** $5,600 Individual/$11,200 Family Deductible *Includes Pediatric Dental, Preventive Drug List*	☐ **Community Preferred (Silver)** $2,600 Individual/$5,200 Family Deductible *Includes Pediatric Dental, Chronic Illness Support Program*
☐ **Community Beacon HSA (Silver)** $3,500 Individual/$7,000 Family Deductible *Includes Pediatric Dental, Preventive Drug List*	☐**Community Merit (Silver)** $2,500 Individual/$5,000 Family Deductible *Includes Pediatric Dental, Chronic Illness Support Program*
☐**Community Core HSA (Silver)** $3,000 Individual/$6,000 Family Deductible *Includes Pediatric Dental, Preventive Drug List*	☐ **Community Flex (Gold)** $2,000 Individual/$4,000 Family Deductible *Includes Pediatric Dental, Chronic Illness Support Program*
☐ **Community Balance HSA (Silver)** $2,700 Individual/$5,400 Family Deductible *Includes Pediatric Dental, Preventive Drug List*	☐**Community Prime (Gold)** $1,500 Individual/$3,000 Family Deductible *Includes Pediatric Dental, Chronic Illness Support Program*
☐**Community Option (Silver)** $5,000 Individual/$10,000 Family Deductible *Includes Pediatric Dental, Chronic Illness Support Program*	☐**Community Advantage (Gold)** $1,000 Individual/$2,000 Family Deductible *Includes Pediatric Dental, Chronic Illness Support Program*

6. Declination/Waiver of Coverage

To be completed if medical coverage is declined or refused by an eligible employee

Medical Coverage Declined for (please select all that apply):

- ☐Myself
- ☐Spouse/Domestic Partner
- ☐Dependents

Reason for declining coverage:

- ☐Spouse/Domestic Partner Group coverage
- ☐Medicare
- ☐Medicaid
- ☐Individual coverage
- ☐Retiree coverage
- ☐Parental Group coverage
- ☐COBRA coverage
- ☐TRICARE Military coverage
- ☐Do not want coverage (I understand that I may face a tax penalty for not having health insurance imposed by the IRS)
- ☐Other (please specify): _____

I acknowledge I have been given the right to apply for this coverage; however, I am electing not to enroll. By declining this coverage I acknowledge that I and/or my dependents may have to wait until the plan's next anniversary date to be enrolled for group coverage.

Please sign here ONLY IF YOU ARE DECLINING coverage for yourself or dependent(s).

Employee Signature_____

Date _____/_____/_____

Items marked with an * are a required field.

7. Legal Acknowledgements and Signature

I understand that:

- ☐ I will receive notice by mail of my Membership status with Community Health Options once Community Health Options has received and processed my application. Upon notification of Membership, I will receive a Member ID Card, online access to the applicable Member Benefit Agreement and any other necessary documents relating to my Community Health Options Membership and coverage.
- ☐ If I or any covered family member is insured by more than one health contract, coordination of benefits will apply. Coordination of benefits ensures that the total benefits received from all contracts do not exceed the actual cost of covered services.
- ☐ I am requesting coverage for myself and all dependents listed on this application. All statements and answers I have given are true and complete. I understand any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact found in this application may result in denial of benefits, rescission, or cancellation of my coverage(s). I understand all benefits are subject to the conditions stated in the Member Benefits Agreement.

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Applicant's Signature*_____

Print Name*_____

Date* ____ / ____/ ____

If you would like to access your plan materials electronically and opt-out of paper copies please check here ☐

Email Address:_____

Items marked with an * are a required field.