COMMUNITY Health Options™

2022 Employee Enrollment/Change Form

PLEASE USE BLACK OR BLUE INK ONLY

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

Instructions: Complete this form to elect or decline your healthcare coverage with Community Health Options. If you are electing coverage, complete all sections of the form, except for section 3. If you are declining coverage, complete section 3 only. Please submit this form to your Human Resources Department.

1. EMPLOYER INFORMATION

Must be completed for both Enrollment and Waiver

Employer Name	Employer Address	Group # (if known)

2. EMPLOYEE INFORMATION

Must be completed for both Enrollment and Waiver

Name (Last/First/Middle Initial)	Date of Birth	Date of Hire	Social Security Number:
Physical Address			Apt./Suite #
City	State		ZIP Code
Mailing Address (if different from physical address)			Mailing Apt./Suite #
Mailing City	Mailing State		Mailing ZIP Code
Email address			Phone ( ) - O Home O Mobile O Work

3. DECLINATION/WAIVER OF COVERAGE

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

Medical Coverage Declined for (select all that apply):

- O Myself
- O Spouse/Domestic Partner
- O Dependents

Reason for declining coverage:

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

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4. ENROLLMENT INFORMATION

Must be completed if Employee is taking coverage

Enrollment reason

- O Open Enrollment – New Enrollment
- O Open Enrollment – Renewal
- O New Hire
- O Rehire/Reinstatement
- O COBRA Continuation
- O Decline Coverage
- O Life Event (Complete SpecialEvent and Coverage Change Sections)

Date of Event: _____/_____/_____
*Requested Effective Date:
_____/_____/_____

Special Event (Required for Life Event)

- O Birth or adoption
- O Court Order
- O Marriage
- O Divorce, separation, or annulment
- O Death
- O Employment or benefit eligibility status change
- O Medicare/Medicaid eligibility event
- O Losing access to other coverage
- O Termination of Employment
- O Other: _____

Coverage Change
(Required for Life Event)

- O Cancel Coverage
- O Add Spouse/Domestic Partner
- O Remove Spouse/Domestic Partner
- O Add Dependent
- O Remove Dependent
- O Name Change
- O Address Change
- O Other Change_____

*Coverage must begin on the first of the month and end on the last day of the month, except for birth, adoption, or death.

5. EMPLOYEE AND FAMILY MEMBER INFORMATION

Must be completed if Employee is taking coverage

Please complete information for eligible family members you wish to cover, delete or change

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 coverage 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		
	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 and domestic partner and dependent eligibility is subject to your employer's eligibility guidelines.

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6. MEDICAL COVERAGE (Select one plan offered by your Employer)

Must be completed if Employee is taking coverage

O **Community Progress New England (Bronze)** $8,700 Individual/$17,400 Family Deductible	O **Community Preferred New England (Silver)** $3,400 Individual/$6,800 Family Deductible
O **Community Progress (Bronze)** $8,700 Individual/$17,400 Family Deductible Includes Pediatric Dental	O **Community Preferred (Silver)** $3,000 Individual/$6,000 Family Deductible Includes Pediatric Dental, Chronic Illness Support Program
O **Community Access HSA (Bronze)** $7,000 Individual/$14,000 Family Deductible Includes Pediatric Dental, Preventive Drug List	O **Community Balance HSA (Silver)** $2,800 Individual/$5,600 Family Deductible Includes Pediatric Dental, Preventive Drug List
O **Community Shield (Bronze)** $6,500 Individual/$13,000 Family Deductible Includes Pediatric Dental, Chronic Illness Support Program	O **Community Flex (Gold)** $2,000 Individual/$4,000 Family Deductible Includes Pediatric Dental, Chronic Illness Support Program
O **Community Option HSA (Bronze)** $6,200 Individual/$12,400 Family Deductible Includes Pediatric Dental, Preventive Drug List	O **Community Premier (Gold)** $2,000 Individual/$4,000 Family Deductible Includes Pediatric Dental, Chronic Illness Support Program
O **Community Peak (Silver)** $6,200 Individual/$12,400 Family Deductible Includes Pediatric Dental	O **Community Elite New England (Gold)** $1,500 Individual/$3,000 Family Deductible
O **Community Option (Silver)** $5,000 Individual/$10,000 Family Deductible Includes Pediatric Dental, Chronic Illness Support Program	O **Community Elite (Gold)** $1,500 Individual/$3,000 Family Deductible Includes Pediatric Dental, Chronic Illness Support Program
O **Community Accord (Silver)** $4,000 Individual/$8,000 Family Deductible Includes Pediatric Dental, Chronic Illness Support Program	O **Community Prime (Gold)** $1,500 Individual/$3,000 Family Deductible Includes Pediatric Dental, Chronic Illness Support Program
O **Community Core HSA (Silver)** $3,000 Individual/$6,000 Family Deductible Includes Pediatric Dental, Preventive Drug List	O **Community Advantage (Gold)** $1,000 Individual/$2,000 Family Deductible Includes Pediatric Dental, Chronic Illness Support Program

7. 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

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8. LEGAL ACKNOWLEDGEMENTS AND SIGNATURE

Must be completed if Employee is taking coverage

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 _____ /_____ /_____