Heritage University

ID #: ____________

Group Number: 020434

Medical/Prescription/Vision/Dental

Health Plan Enrollment and Change Form

Plan Selection

Date of Hire: ________________ Effective Date: ________________

I elect the following coverage for myself: ☐ $500 Deductible ☐ $1,000 Deductible ☐ Dental
☐ $2,000 (HSA) Deductible ☐ $3,000 Deductible ☐ Decline Coverage

Employee Information

Name: ____ Gender: ☐ Male ☐ Female
Last Name First Name MI

Home Address: ____
City State Zip

Social Sec No: ____________________ Birthdate: ____________________________

Phone #: _______________________ Email Address: ________________________

Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Legally Separated

Proof of Dependent Eligibility is required. Please provide a copy of Marriage/Birth Certificate, Court Order of Affidavit of Qualifying Domestic Partnership.

Dependent Information

Benefit Election	Name (Last, First, MI)	Other Coverage	Social Security No.	Birthdate	Gender	Add/Drop	Relationship to Employee
☐ Medical	Name: ________________	☐ Yes	__________	________	☐ M	☐ Add	____________
☐ Dental		☐ No			☐ F	☐ Drop	
				If Child is over age 26, is child Disabled: ☐ Yes ☐ No			
☐ Medical	Name: ________________	☐ Yes	__________	________	☐ M	☐ Add	____________
☐ Dental		☐ No			☐ F	☐ Drop	
				If Child is over age 26, is child Disabled: ☐ Yes ☐ No			
☐ Medical	Name: ________________	☐ Yes	__________	________	☐ M	☐ Add	____________
☐ Dental		☐ No			☐ F	☐ Drop	
				If Child is over age 26, is child Disabled: ☐ Yes ☐ No			
☐ Medical	Name: ________________	☐ Yes	__________	________	☐ M	☐ Add	____________
☐ Dental		☐ No			☐ F	☐ Drop	
				If Child is over age 26, is child Disabled: ☐ Yes ☐ No			
☐ Medical	Name: ________________	☐ Yes	__________	________	☐ M	☐ Add	____________
☐ Dental		☐ No			☐ F	☐ Drop	
				If Child is over age 26, is child Disabled: ☐ Yes ☐ No			
☐ Medical	Name: ________________	☐ Yes	__________	________	☐ M	☐ Add	____________
☐ Dental		☐ No			☐ F	☐ Drop	
				If Child is over age 26, is child Disabled: ☐ Yes ☐ No			

Other Coverage

Please complete the following information if you or any dependent listed is covered under another health plan:

Covered Individual	Carrier Name & Phone No.	ID/Policy No.	Effective & Term Date	Coverage (Medicare, Medical, Dental, Vision)

Change

If Changing Coverage, please give reason for change: (*Please specify on pg. 1 what coverage you want to cancel)*

☐ Drop Spouse/Dependent Date: ________________ Reason: ____

☐ Cancel Coverage (self) Date: ________________ (*last day of coverage*) ☐Medical ☐Dental

☐ Add Spouse/Dependent Reason: ____________________________ Date, Marriage/Birth: __________________

If adding Spouse of Domestic Partner, a copy of the Marriage Certificate or Affidavit of Qualifying Domestic Partner is required
If adding Dependent Child due to adoption, court order or legal guardianship, you must provide legal documentation.

☐ Taking a Leave of Absence Date: ________________ Continue Coverage during leave: ☐ Yes ☐ No

☐ Returning from LOA Date: ________________

Acceptance

This Application is made for benefits under the Heritage University Health and Welfare Plan for which I am eligible. Authorization is granted to deduct from my wages any premiums required to participate. I certify the above information to be correct and true to the best of my knowledge and that those listed as dependents qualify as such under the terms of the Plan. I understand that all entitlements to benefits are void, and coverage may be canceled or modified retroactively to its effective date if I have made intentionally false or misleading statements or answers on behalf of myself or any family member. I authorize any person or institution providing care or services, or any organization in possession of insurance benefit information to release any and all information providing care or services, or any organization in possession of insurance benefit information to release any and all information pertaining to the care or benefits provided to me or my dependents to HMA or its designated agent. This form replaces all previous forms and submissions I have made for coverage.

Applicant Signature: ____ Date: ___________________