

# Enrollment/Change Form

Lovelace Health Plan  
Lovelace Health System, Inc. • Lovelace Insurance Company

<b>FOR INTERNAL USE ONLY</b>	
Member # LH--	
Processed by	Date

Employer: Complete Section A, C, E  
Employee: Complete Sections B, D, E  
Health Plan: Complete Section F

Please **print clearly and complete each section of this form.**  
Thank you for providing this information.  
*\*Illegible and/or incomplete forms will be returned and will delay processing\**

A	<input type="checkbox"/> Open Enrollment <input type="checkbox"/> Change <input type="checkbox"/> New Enrollment <input type="checkbox"/> Reinstatement <input type="checkbox"/> Other (reason) _____	Employee Title	Date of Hire	Hours Worked	Effective Date of Coverage	Employer Name	LHP/LINC Group No.	Subgroup No.	Class
	TYPE OF CHANGE <input type="checkbox"/> <b>Address Change</b> <input type="checkbox"/> <b>Add Dependent(s)*</b> <input type="checkbox"/> Birth <input type="checkbox"/> Marriage <input type="checkbox"/> Adoption Placement <input type="checkbox"/> Other Date of Change _____		<input type="checkbox"/> <b>Cancel Employee</b> <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Other Insurance <input type="checkbox"/> Other Date _____		<input type="checkbox"/> <b>Cancel Dependent(s)*</b> * List Name in Section B <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Other Date of Above Event _____		<input type="checkbox"/> <b>Transfer to Cobra</b> * List Name in Section B <input type="checkbox"/> 18 mos. <input type="checkbox"/> 29 mos. <input type="checkbox"/> 36 mos. - or -		<input type="checkbox"/> 6-month State continuation <input type="checkbox"/> Family Security Benefit/ Surviving Spouse <input type="checkbox"/> Retirement <input type="checkbox"/> Other

B	Employee Name (LAST)	(FIRST)	(M.I.)	Social Security No.	Date of Birth	Employee Gender <input type="checkbox"/> M <input type="checkbox"/> F	Day Phone ( )	
	Physical Address (STREET)	(CITY)	(STATE)	(ZIP)	E-mail Address	Evening Phone ( )		
	Mailing Address (STREET)	(CITY)	(STATE)	(ZIP)	Primary Care Physician (PCP)	Existing Patient of PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No		
I WOULD LIKE COVERAGE FOR MY DEPENDENTS (*). <i>(Specify last name if different from yours)</i> <i>If enrolling more than 3 dependents use a second form</i>								
	Last Name (if different than yours)	First Name	M.I.	Relationship	Social Security Number	Date of Birth Mo./Day/Year	<b>Primary Care Physician</b> Provide <u>First</u> AND <u>Last</u> name of physician. Please indicate the provider number from the Lovelace provider directory (if directory is available to you). If none is selected, one will be assigned to you.	Existing Patient
	Spouse/Domestic Partner			<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner Date of Marriage ___/___/___ City, State in which married _____			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N
	Dependent*			<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other <input type="checkbox"/> Natural Child <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Employee Legal Guardian of Child <input type="checkbox"/> Court-ordered coverage <input type="checkbox"/> Physical/Mentally Impaired (*)			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N
	Dependent*			<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other <input type="checkbox"/> Natural Child <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Employee Legal Guardian of Child <input type="checkbox"/> Court-ordered coverage <input type="checkbox"/> Physical/Mentally Impaired (*)			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N
	Dependent*			<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other <input type="checkbox"/> Natural Child <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Employee Legal Guardian of Child <input type="checkbox"/> Court-ordered coverage <input type="checkbox"/> Physical/Mentally Impaired (*)			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N

(\* If physically or mentally impaired and over the group limiting age, please attach medical records for eligibility review.

C	<b>Offered by Lovelace Health System, Inc.</b>			<b>Offered by Lovelace Insurance Company</b>		
	Medical Coverage Options:	<input type="checkbox"/> Platinum Coverage <input type="checkbox"/> Premier Coverage <input type="checkbox"/> Primary Coverage	<input type="checkbox"/> Select Coverage <input type="checkbox"/> Point of Service <input type="checkbox"/> Individual Conversion	Rx Rider Option	<input type="checkbox"/> Select PPO Coverage <input type="checkbox"/> Classic PPO <sup>1</sup> (submit Certificate of Creditable Coverage, if applicable) <input type="checkbox"/> Other _____	Rx Rider Option

D	<b>Other Health Care Coverage:</b> Do you or your dependents have other health insurance under a group plan, HMO, or Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the following						Medicare Part	
	Name of Person Covered	Date of Birth	Employee Name	Employer Name	Member ID #	Insurance Co. Name and Address	Type of Coverage	A B D <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
							<input type="checkbox"/> Medicare End-Stage Renal Disease <input type="checkbox"/> Medicare End-Stage Renal Disease	

E	I have read the descriptive literature outlining the medical plan and I hereby apply for participation in said plan. I authorize my employer to deduct from my earnings the employee's contribution, if any, to the premium under the Agreement (contract). I also authorize the health care provider from which I or my dependents receive health care services to disclose to the Insurer any information concerning me or my dependents contained in the records of the health care provider. I understand that membership may be automatically terminated if I have given any fraudulent information regarding myself or dependents on this application. I agree that all sums payable by other health plans (including Medicare, Medicaid, Champus and Workers Compensation) shall be payable to and retained by the Insurer. I agree for myself and my dependents to complete and submit to the Insurer such consents, releases, assignments and other documents requested by the Insurer to assure such payment.							
	SIGNATURE – The information provided above is complete and correct to the best of my knowledge. I agree on behalf of myself and my covered dependents to the provisions this form.							
	Subscriber Signature	Date	Employer Verification Signature	Date				

## FOOTNOTES

- 1 This plan imposes a Pre-existing Condition exclusion for applicants 19 years of age or older. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. If you have prior health/credible coverage, please attach your HIPAA Certificate of Credible Coverage with this application.

## PROVISIONS

I authorize deductions from my earnings of the required contributions, if any, toward the cost of the coverage. This authorization applies only if employee contributions are required.

### APPLICABLE TO BENEFITS

- I authorize payment of any and all benefits payable under the policy to any licensed provider of care who treats me and/or my covered dependents.
- Lovelace Health System, Inc. or Lovelace Insurance Company provides health coverage under an agreement with my employer.
- I understand that the Participating Providers, if any, do not necessarily include all types of doctors or providers.
- I authorize any Provider, Insurance Company, Employer or Organization to release necessary information on me or my dependents regarding medical, dental, mental health or substance abuse history, treatment or benefits payable, to the Plan Administrator, its authorized agent, the Insurer entity administering this plan or my primary care physician for the purpose of determining benefits in connection with this plan or quality assessment purposes. This authorization for release of substance abuse history, treatment or benefits payable is subject to revocation at any time except to the extent that disclosure of such information has already been made to the Plan Administrator, its Authorized Agent, the Insurer entity administering this plan or my primary care physician.
- I authorize payment of any and all benefits payable under the policy to the Participating Provider of the benefits who treats me and/or my covered dependents.
- I authorize that payment be made under Medicare to the Insurer for medical and other services furnished me for which it pays or has paid, if applicable.
- I agree, for myself and my dependents, that, in the event any health services provided are the primary responsibility of any other party by way of other group health coverage or by the act or omission of another person to fully inform the Insurer and will execute such assignments, liens or other documents which may be necessary to enable the Insurer to recover the value or the services provided. I further agree that in the event I or any of my dependents collect benefits or damages from any other party who has primary responsibility for the services provided by the Insurer I will immediately reimburse the Insurer to the extent of the services provided, to the extent permitted by state law.
- All statements, in the absence of fraud, or an intentional false statement of an important fact, made by the Member or Subscriber shall be deemed representations and not warranties, and that no such statement shall void the insurance or reduce benefits there under unless contained in a written application for such insurance.

## LATE ENROLLMENT

- Late enrollments will not be accepted.

## AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

I understand that it is necessary for the parties administering the plan in which I am enrolling to obtain and/or provide to others "Confidential Information," as defined below. Therefore:

- I authorize any person or entity having Confidential Information to provide any such Confidential Information upon request to the Insurer, any Participating Provider, or any other provider or entity performing a service for the purpose of eligibility determination under the plan, the administration of the plan, the performance of any insured program or operations, or assessing quality and accessibility of health care services and supplies.
- I authorize the Insurer to disclose any Confidential Information to any person, company, or entity when it determines that such disclosure is necessary or appropriate for the administration of the plan, the performance of insured programs or operations, assessing quality and accessibility of health care services and supplies, or reporting to third parties involved in plan administration.
- I am making this authorization for myself and as the agent or representative of my covered dependents OR representative of my spouse, domestic partner (if applicable) and any dependent children. I understand that it will remain in effect until I send written notice revoking it to the Insurer or for such shorter period as required by law. Until revoked, this authorization may be relied upon by the Insurer and other parties. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.
- "Confidential Information" means, with respect to me and any covered dependents, any medical, dental, mental health, substance abuse, communicable disease, AIDS and HIV related information and disability or employment related information.
- "Insurer" means Lovelace Health System, Inc. and Lovelace Insurance Company.
- This authorization shall be valid for two years from this date and may be revoked by sending written notice to Lovelace.