Lovelace Community Health Plan

SCI – State Coverage Insurance

NEW EMPLOYER GROUP ENROLLMENT/CHANGE FORM

Please **print clearly and complete each section of this form**.
Note: Illegible and/or incomplete forms will be returned and will delay processing

IT IS IMPORTANT THAT YOU ATTACH A COPY OF YOUR STATE CERTIFICATION TO THIS FORM

LOVELACE HEALTH PLAN USE ONLY		
Member # LH-		
MCD ID -		
County Code	COE	Race Code
Cert Effective Date	Out-of-Pocket Max $	
Eligibility Begin Date		

ENROLLMENT	CHANGE	TERMINATION	
☐ New Enrollment ☐ Recertification Effective Date: ____________	☐ Name ☐ Address	Date of Termination: ____________ Reason: ☐ Obtain Other Insurance ☐ Other	
GROUP NAME:	GROUP NUMBER:	SUBGROUP:	CLASS:

Employee (LAST)	Employee Name (FIRST)		Employee Middle Initial
Permanent Residence Address (Street)	(City)	(State)	(Zip)
Mailing Address *(if different from above)* (Street)	(City)	(State)	(Zip)
Area Code / Phone No.	Birth Date	Social Security Number	

Employee Gender	Native American?	Primary Language Spoken	Primary Care Physician (PCP). Please include FIRST AND LAST NAME OF PCP and location.	Existing Patient of PCP?
☐ Male ☐ Female	☐ Yes ☐ No	☐ English ☐ Spanish ☐ Other ________	Name Street City, State, Zip	☐ Yes ☐ No

☐ Employed ☐ Self-employed

Si prefiere el material de post-inscripción en Español, por favor marque aquí. ☐

I have read the summary outlining the Lovelace State Coverage Insurance Program (SCI) and I would like to enroll in the Plan. I agree to pay the premiums and co-payments as required with the Plan summary. I also give permission to the health plan provider from which I receive health care services to release to Lovelace any information concerning me in the records of the health care provider. I understand that the benefits and cost-sharing requirements of the SCI program are subject to regulatory changes. I further understand that there is a $100,000 maximum limit per benefit year and that I will be responsible for any charges received after I reach the $100,000 benefit limitation. I must return this enrollment form, my approval letter from the Income Support Division, and required premium payment by the 20th of the month in order to be eligible by the first day of the following month. I confirm that I do not currently have insurance or have not voluntarily disenrolled from an insurance plan in the last six months. I understand that I may be automatically terminated if I have provided any false information during the application process.

The information provided above is true and correct to the best of my knowledge.

Employee Signature ______________________ Date ____________

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ENROLLMENT	CHANGE	TERMINATION
☐ New Enrollment ☐ Recertification Effective Date: _____________	☐ Name ☐ Address	Date of Termination: _____________ Reason: ☐ Obtain Other Insurance ☐ Other

GROUP NAME:	GROUP NUMBER:	SUBGROUP:	CLASS:

Spouse (LAST)	Spouse Name (FIRST)	Spouse Middle Initial

Permanent Residence Address (Street)	(City)	(State)	(Zip)
Mailing Address *(if different from above)* (Street)	(City)	(State)	(Zip)

Area Code / Phone No.	Birth Date	Social Security Number

Spouse Gender	Native American?	Primary Language Spoken	Primary Care Physician (PCP). Please include FIRST AND LAST NAME OF PCP and location.	Existing Patient of PCP?
☐ Male ☐ Female	☐ Yes ☐ No	☐ English ☐ Spanish ☐ Other ________	Name Street City, State, Zip	☐ Yes ☐ No

☐ Employed ☐ Self-employed

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The information provided above is true and correct to the best of my knowledge.

Spouse Signature ______________________ Date ______________