# BUTLER HEALTH PLAN — ENROLLMENT/CHANGE FORM

## 1. EMPLOYEE INFORMATION

**Group # A08103 for Allied Benefit Systems**

| Last Name | First Name M.I. | SS# - - | | |
|---|---|---|---|---|
| Address Apt# | City | | State | Zip |
| Home Phone ( ) | Cell Phone ( ) | Work Phone ( ) | Sex ☐ Male ☐ Female | Birth Date / / |
| E-mail | Employer Location | | Marital Status | ☐Single ☐Divorced ☐Married ☐Widowed |

## 2. PLAN SELECTION

**Check box to enroll in selected plan.**

| ***Medical Plan*** | ☐ Employee<br>☐ Employee + 1<br>☐ Family | ☐ PPO<br>☐ HDHP | ***Dental Plan*** | ☐ Employee<br>☐ Employee + 1<br>☐ Family |
|---|---|---|---|---|

**➔ IF WAIVING MEDICAL AND/OR DENTAL COVERAGE YOU MUST COMPLETE AND SIGN SECTION 8**

## 3. CHANGE (Qualifying Event)

**Effective date of change: / /**

**Check reason for change**: ☐ Newborn ☐ Adoption ☐ Marriage ☐ Divorce ☐ Death ☐ Child no longer eligible

☐ Change in spouse's employment or insurance coverage ☐ Change in dependent status-State reason:

## 4. FAMILY INFORMATION

**List covered dependents. Check this box ☐ if attaching list of additional dependents.**

| *Relationship* | *Dependent First Name MI Last Name Social Security Number (SS#)* | *Sex* | *Birth Date Mth/Day/Year* | *Child resides with you?* | *Child is your IRS dependent?* | *Full Time Student?* | *Check coverage that apply:* |
|---|---|---|---|---|---|---|---|
| Spouse | Name____________<br>SS# - - | ☐ M<br>☐ F | / / | | | | ☐ Medical<br>☐ Dental |
| ☐ Natural<br>☐ Adopted<br>☐ Step<br>☐ Court Order | Name____________<br>SS# - - | ☐ M<br>☐ F | / / | ☐ Yes<br>☐ No | ☐ Yes<br>☐ No | ☐ Yes<br>☐ No | ☐ Medical<br>☐ Dental |
| ☐ Natural<br>☐ Adopted<br>☐ Step<br>☐ Court Order | Name____________<br>SS# - - | ☐ M<br>☐ F | / / | ☐ Yes<br>☐ No | ☐ Yes<br>☐ No | ☐ Yes<br>☐ No | ☐ Medical<br>☐ Dental |
| ☐ Natural<br>☐ Adopted<br>☐ Step<br>☐ Court Order | Name____________<br>SS# - - | ☐ M<br>☐ F | / / | ☐ Yes<br>☐ No | ☐ Yes<br>☐ No | ☐ Yes<br>☐ No | ☐ Medical<br>☐ Dental |
| ☐ Natural<br>☐ Adopted<br>☐ Step<br>☐ Court Order | Name____________<br>SS# - - | ☐ M<br>☐ F | / / | ☐ Yes<br>☐ No | ☐ Yes<br>☐ No | ☐ Yes<br>☐ No | ☐ Medical<br>☐ Dental |
| ☐ Natural<br>☐ Adopted<br>☐ Step<br>☐ Court Order | Name____________<br>SS# - - | ☐ M<br>☐ F | / / | ☐ Yes<br>☐ No | ☐ Yes<br>☐ No | ☐ Yes<br>☐ No | ☐ Medical<br>☐ Dental |

## 5. OTHER MEDICAL/RX COVERAGE

Is your spouse employed? ☐ Yes ☐ No

Is your spouse enrolled in his/her employer-sponsored or retiree medical plan? ☐ Yes (If "Yes," complete the rest of Section 5 - Other Medical/Rx Coverage.) ☐ No (If "No," you must complete a COB Questionnaire.)

| Name and Address of Employer | | | |
|---|---|---|---|
| Name of Medical Insurance or TPA | Policy Number | | |
| Address of Medical Insurance or TPA | City | State | Zip |

List your spouse & dependents with other Medical/Rx coverage. Use the following codes to indicate other coverage for dependents enrolled in BHP.

*1) Employer Provided Medical/Rx* *3) TriCare Military Coverage* *5) Medicare/Medicaid* *7) No other coverage*

*2) Retirement Plan Medical/Rx* *4) Parent Court Order* *6) Other (Attach Explanation)*

| Name | Other Medical | Other Rx Coverage |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Please Complete Reverse Side**

## 6. OTHER DENTAL COVERAGE

Do you or any of your family members have other group dental insurance? ☐ Yes ☐ No

| If yes, Name of Dental Policy Holder | | | SS# - - |
|---|---|---|---|
| Name of Dental Insurance or TPA | Policy Number | | |
| Address of Dental Insurance or TPA | City | State | Zip |

List Dependents Covered:

## 7. SIGNATURE REQUIREMENT - READ AND SIGN

**Any person who knowingly and with intent to defraud, files a statement containing any materially false information or conceals, for the purpose of misleading information concerning any fact material thereto, commits fraud which is a crime and could jeopardize your coverage.**

**I hereby consent and authorize any dentist, physician, supplier, hospital, pharmacy, insurance company, employer or organization to disclose any medical information concerning myself or my dependents to the Butler Health Plan or its agents or contractors for the purpose of administering, supervising and monitoring the health Plan(s). I further consent to the subsequent disclosure of medical information concerning myself or dependents by Butler Health Plan or its agents or contractors to contractors who provide wellness, disease management, case management or other health and health care related services to Butler Health Plan and/ or its participants. This consent shall be valid until revoked in writing by the employee.**

| Employee Signature | Date |
|---|---|
| Print Employee Name | |

## 8. WAIVER OF COVERAGE- READ AND SIGN IF YOU REFUSE COVERAGE FOR YOURSELF AND DEPENDENTS.

☐ Waive medical coverage due to: ☐ Have other medical coverage or ☐ Other (Please explain)____________________________________________

☐ Waive dental coverage due to: ☐ Have other dental coverage or ☐ Other (Please explain)____________________________________________

**I understand, if in the future I decide to apply for group medical benefits, additional limitation and waiting periods may apply.**

| Employee Signature | Date |
|---|---|
| Print Employee Name | |

## REQUIRED LEGAL DOCUMENTATION

| Dependent Type | Submit Copy of Preferred Documentation | Alternate Document |
|---|---|---|
| **Spouse** | Marriage certificate | In case "Preferred Documentation" is not available, you may use your most recent tax return with the financial information blacked out in order to prove dependent status. |
| **Birth Child Under Age 26** | Birth certificate | |
| **Adopted Child Under Age 26** | Adoption certificate | |
| **Legal Guardianship for Child Under Age 26** | Proof of legal guardianship | |
| **Stepchild Under Age 26** | Divorce decree identifying medical coverage for dependents | |
| **Child Age 19-25 Who is a Full Time Student …For Dental Plan only** | **1.** Appropriate documentation as listed above for birth, adopted or legal guardian status **AND 2.** One of the following from the current school term to demonstrate full-time student status: Grade report, school registration, transcripts or letter from school showing full time student status. | |
| **How to Waive Pre-existing Conditions -** Some or all of the pre-existing condition waiting period may be waived under the terms of the HIPAA Act of 1996. | A Certificate of Credible Coverage or other documentation of prior health coverage for you and your dependents over age 19 must be attached or forwarded to the Butler Health Plan Claim Administrator, Allied Benefit Systems. | |

**TO BE COMPLETED BY EMPLOYER:** ***Effective Date of Change: / /*** ***Date of Hire: / /***

☐ New Enrollment ☐ Cancellation ☐ Name Change

☐ Re-Enrollment ☐ Open Enrollment ☐ Address Change

☐ Dependent Status Change-State Reason: ☐ Other-State Reason: