HealthComp
Third Party Administrators

Oak Valley Hospital District

# GROUP ENROLLMENT/CHANGE FORM

P.O. BOX 45018,
FRESNO, CA 93718-5018
(800) 442-7247 FAX (559) 499-2464

☐ New Enrollment
☐ Name/Address Change
☐ Reinstatement
☐ Rehire
☐ Annual Enrollment
☐ Change Enrollment
☐ Decline Coverage
☐ Termination

## PART 1 EMPLOYEE INFORMATION

| EMPLOYER | GROUP NUMBER | BENEFIT TYPE : | EFFECTIVE DATE | | | |
|---|---|---|---|---|---|---|
| Oak Valley Hospital | G10 | ☐ MEDICAL ☐ DENTAL ☐ VISION ☐ LIFE | MEDICAL | DENTAL | VISION | LIFE |

| EMPLOYEE LAST | FIRST | MI | SOCIAL SECURITY NUMBER |
|---|---|---|---|
| | | | |

| ADDRESS STREET | CITY | STATE | ZIP CODE | HOME PHONE ( ) | BIRTHDATE MO | DAY | YEAR |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

| HIRE DATE | JOB TITLE | ☐ MALE ☐ FEMALE | ☐ SINGLE ☐ MARRIED ☐ DOMESTIC PARTNER ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED | DEPARTMENT |
|---|---|---|---|---|
| | | | | |

| EMPLOYEE TERMINATION DATE | REASON FOR TERMINATION | ID CARD FORMAT | MASK |
|---|---|---|---|
| | | | |

## PART 2 DEPENDENT INFORMATION

**DEPENDENT INFORMATION (List persons to be covered/terminated.):** [1] **Relationship Code (relationship to participant)** **SPO=**Spouse **DP=Domestic Partner** **SON=**Son **DAU=**Daughter **DEP=**Other Dependent

| Add/Drop | Last Name | First Name | MI | Social Security Number | Birth Date | Gender | Rel. Code 1 | (M) MEDICAL / (D) DENTAL /(V) VISION | Disabled |
|---|---|---|---|---|---|---|---|---|---|
| A D | | | | | | M F | | | Y N |
| A D | | | | | | M F | | | Y N |
| A D | | | | | | M F | | | Y N |
| A D | | | | | | M F | | | Y N |
| A D | | | | | | M F | | | Y N |

**IF ADDING OR DROPPING DEPENDANT STATE REASON:**

## PART 3 OTHER INSURANCE INFORMATION

**ARE YOU OR ANY OF YOUR DEPENDENTS (INCLUDING SPOUSE) COVERED UNDER ANOTHER HEALTH PLAN OR MEDICARE?** ☐YES ☐NO **IF YES, PLEASE COMPLETE THIS SECTION.** **Check if additional form attached.** ☐

| Name of other policy holder | Birth Date | Social Security Number | [3] Rel. Code | Sponsoring Employer | Insurance Carrier or Medicare | Group Number | [4] Benefit Types | [5] Policy Types | Coverage Date(s) |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | Begin / / End / / |

**PERSONS COVERED UNDER ABOVE POLICY:**

3 **Relationship Code** (specify relation to participant): SPO=Spouse OTH=Other | 4 **Benefit Type(s)**: **M**=Medical **D**=Dental **V**=Vision **Rx**=Prescription | 5 **Policy Type**(s): **IND**=Individual Policy **GRP**=Group Plan **HMO**=Health Maintenance Organization **MED**=Medicare

## PART 4 COVERAGE DECLINATION

**To be completed if any coverage is declined or refused by an eligible employee and / or their eligible family members;**

**HEALTH PLAN COVERAGE (CHECK IF DECLINING)**
I decline coverage for:
☐ Myself ☐ Children
☐ Spouse ☐ Spouse and Children

**REASON FOR DECLINING HEALTH COVERAGE (CHECK IF DECLINING)**
☐ Covered by spouse's group coverage
☐ Spouse covered by employer's group medical coverage
☐ Medicare
☐ Other (explain) _____

I acknowledge that the available coverages have been explained to me by my employer, and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any, and understand that evidence of insurability may be required should I choose to apply for coverage at a later date. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage.

_____ _____
If declining coverage for employee/dependent(s) please sign here. Date

## PART 5 DECLARATION

☐ I hereby request the amount of coverage for which I may become eligible under the group employee benefits plan of my employer and authorized payroll deductions from my earnings (if any) required to cover my share of the premium. I confirm the above beneficiary information.

_____ _____
Employee's Signature Date

*Revised 07.02.12*