GUARDIAN Health Net

Bridgewater Office
P.O. Box 425
E. Bridgewater, MA 02333-0425

• Please Print clearly and in Black or Blue ink
• Please Print in Capital Letters only

Guardian & Health Net Healthcare Solutions
ENROLLMENT/CHANGE FORM - CONNECTICUT

Planholder Name (Company Name)	Group Plan Number	Division	Class

PLEASE CHECK APPROPRIATE BOX ☐ Initial Enrollment/Refusal of Coverage (Complete Sections 1, 3, 4, 6) ☐ Add Employee/Dependents (Complete Sections 1, 3, 5, 6) ☐ Drop/Refuse Coverage (Complete Sections 2, 4, 6) ☐ Information Change (Complete Section 6)

SECTION 1

☐ Add Employee
- ☐ New Hire
- ☐ Previously refused this coverage
- ☐ Loss of Other Coverage (Complete Section 5 if applicable)

☐ Add Spouse
- ☐ Marriage Date _____/_____/_____
- ☐ Previously refused this coverage
- ☐ Loss of Other Coverage (Complete Section 5 if applicable)

☐ Add Children
- ☐ Newborn
- ☐ Previously refused this coverage
- ☐ Adoption Date _____/_____/_____
- ☐ Loss of Other Coverage (Complete Section 5 if applicable)

SECTION 2

☐ Drop Employee (Complete Section 4) ☐ Drop Dependents (Complete Section 4)
The date of withdrawal cannot be prior to the date this form is completed and signed.
- ☐ Termination of Employment
- ☐ Retirement
  Last Day Worked _____/_____/_____
  Last Day of Coverage _____/_____/_____
- ☐ Other _____

SECTION 3

SELECT COVERAGE(S): Dependents cannot be enrolled for coverage refused by the employee.
- ☐ **Medical** ☐ Employee ☐ Spouse ☐ Child(ren)
- ☐ **Life** ☐ Employee ☐ Spouse ☐ Child(ren)
- ☐ **AD&D** ☐ Employee ☐ Family (includes EE, Sp, Ch)
- ☐ **Dental** ☐ Employee ☐ Spouse ☐ Child(ren)
- ☐ **Vision** ☐ Employee ☐ Spouse ☐ Child(ren)
- ☐ **Long Term Disability** (if applicable choose option)
- ☐ **Short Term Disability** (if applicable choose option)

SELECT COVERAGE OPTIONS: Choose only one option for each coverage.
- **Medical** ☐ HMO Advtg. Platinum: ☐ Charter or ☐ Passport
  ☐ POS Advtg. Platinum: ☐ Charter or ☐ Passport
  ☐ PPO Advtg. Platinum
- **Dental** ☐ Indemnity ☐ PPO ☐ Buy-Up ☐ Pre-Paid *
  * Complete Pre-Paid Office # in Section 6
- **LTD** ☐ Buy-Up
  ☐ Flex AbilityGuard $____ (up to 50% of salary)
- **STD** ☐ Buy-Up
  ☐ Flex AbilityGuard $____ (up to 50% of salary)

SECTION 4

REFUSE/DROP COVERAGE(S):
- ☐ **Medical** ☐ Employee ☐ Spouse ☐ Child(ren)
- ☐ **Life** ☐ Employee ☐ Spouse ☐ Child(ren)
- ☐ **AD&D** ☐ Employee ☐ Family (includes EE, Sp, Ch)
- ☐ **Dental** ☐ Employee ☐ Spouse ☐ Child(ren)
- ☐ **Vision** ☐ Employee ☐ Spouse ☐ Child(ren)
- ☐ **Long Term Disability** ☐ **Short Term Disability**

I have been offered the above coverages and wish to refuse/drop enrollment for the following reasons:
- ☐ Covered under another insurance plan
- ☐ Other _____ (additional information may be required)

SECTION 5

LOSS OF OTHER COVERAGE:
I and/or my dependents were previously covered under another group plan. Loss of coverage was due to:
- Termination of Employment _____/_____/_____
- Divorce _____/_____/_____
- Death of Spouse _____/_____/_____
- Term./Expiration of Coverage _____/_____/_____

SECTION 6

Add	Drop	Employee Name: Last	First	MI	Sex	Birth Date (MM DD YYYY)	Social Security Number	Pre-Paid Office # (See directory)	PCP Access # (HMO/POS only)
☐	☐				M F	- -	- -		

Street address _____ City _____ State ZIP _____

Home Phone: ( ) -

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

Are you: ☐ A full-time employee ☐ Retired ☐ Other _____ (additional information may be required) Occupation/Job Title:

Number of hours worked per week: Annual Salary (nearest dollar): , , Date of Full Time Hire (MM DD YYYY): - -

Add	Drop	Dependents Name: Last	First	MI	Sex	Student	Birth Date (MM DD YYYY)	Social Security Number	Pre-Paid Office # (See directory)	PCP Access # (HMO/POS only)
☐	☐				M F		- -	- -		
☐	☐				M F	Y N	- -	- -		
☐	☐				M F	Y N	- -	- -		
☐	☐				M F	Y N	- -	- -		
☐	☐				M F	Y N	- -	- -		

A) Have you included stepchildren? ☐ Yes ☐ No Are they dependent upon you for support and maintenance? ☐ Yes ☐ No
B) Is this your first eligible child? ☐ Yes ☐ No If "no," please list all eligible children above.

Beneficiary Designation: (include full proper name and relationship) Name: Relationship:

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. **The information provided above is true and correct to the best of my knowledge, and I accept the provisions on the reverse side of this form which I have read and understand.**

Signature: _____ Date (MM DD YYYY) - -

DISCLAIMER:
The HMO and Point of Service plan is underwritten by Health Net of Connecticut, Inc. and the PPO plan in underwritten by Health Net Insurance of Connecticut, Inc.

Ancillary lines of coverage are underwritten by Guardian Indemnity Contract Number GP-1-R3-1.0 et al.

REFUSAL OF INSURANCE:
If the plan requires contributions, and I have refused the coverage, the terms for requesting coverage at a later date are as follows: I will not be eligible for the HMO, POS or PPO plans until the next open enrollment period; unless coverage is being discontinued as a result of termination of another plan's coverage, loss of employment, death of spouse, divorce, or unless a court has ordered coverage be provided for a spouse or minor child. To apply for any other coverage, if available, I will be required to furnish, at my own expense, proof of insurability and Guardian reserves the right to reject my request. Proof of insurability does not apply to major medical or dental coverages; however, late entrant penalties may apply.

THE FOLLOWING SPECIAL ENROLLMENT RIGHTS APPLY TO THIS PLAN: If you are declining enrollment for yourself or your dependents because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

AGREEMENT:
I understand the benefits and coverage as summarized in the contract and that these benefits are administered strictly as specified in the contract. I hereby (1) request coverage for the Group program for which I am or may become eligible; (2) authorize my employer to make the necessary deductions for the contributions, if any, required for coverage, or agree that the contribution be added to my dues, if applicable; (3) state that I became an employee on the date stated on this form, and do currently work the number of hours per week stated on this form. I understand that, in order to be accepted for HMO/POS/PPO coverage, my signed and completed application for coverage must be received by Guardian & Health Net within 31 days of my initial eligibility for coverage or within 31 days of the next open enrollment effective date.

I authorize any physician, hospital, insurer or other organization or person having any records or information concerning the health and treatment (including psychiatric and substance abuse) of me and my family member(s) to furnish such records as may be requested by Guardian & Health Net or its authorized representative. A photocopy or digital image of this authorization shall be considered as valid as the original.

I certify that all dependents listed on this form are eligible for coverage under the terms of the contract. I agree to notify Guardian & Health Net and my employer within 31 days when such eligibility ceases. I understand that Guardian & Health Net are not liable to provide coverage for ineligible dependents.

IMPORTANT NOTICE

THE FOLLOWING APPLIES TO THE PPO PLAN.

Preexisting Condition Limitation: This group health plan contains a preexisting condition exclusion that is limited to a maximum of 12 months (18 months for late enrollees). The preexisting condition limitation relates to a condition for which medical advice, diagnosis, care or treatment was recommended or received during the 6 months period prior to an individual's enrollment date. This exclusion period can be reduced by the number of days of your prior creditable coverage. When applying creditable coverage to the preexisting condition limitation, the plan is not required to take into account any days of creditable coverage that precede a break in coverage of 63 days or more. (For Connecticut plans, if your prior creditable coverage was lost due to an involuntary termination of employment, the plan will not take into account any days of creditable coverage that precede a break of more than 120 days prior to your effective date, provided you apply within 63 days of your initial eligibility.) To determine if any preexisting condition limitation will apply to you, you must present your certificate or certificates of prior creditable coverage.

Creditable coverage can include coverage under another group health plan, an individual health policy, Part A or B of Medicare, Medicaid, CHAMPUS, a medical health care program of the Indian Health Service or tribal organization, a state health benefits risk pool, any public health plan, or a health plan issued under the Peace Corps Act.

You may request a certificate of creditable coverage from a previous employer, insurance company or Health Maintenance Organization (HMO). If necessary, your employer and Guardian will assist you in obtaining a certificate from any of these entities.

The Preexisting Condition Limitation notice is being issued to you pursuant to the Federal Health Insurance Portability and Accountability Act of 1996 and reflects the protection afforded under federal law. If the state law applicable to a fully insured Guardian plan is more beneficial to covered individuals as to the length of the preexisting condition limitation and permissible break in coverage, the relevant state law provisions will apply to and be part of your Guardian plan.