CalCPA Health

Employee Enrollment / Change Form

Firm Name: _____

Client Code *(six digit #)*: _____

Illegible or incomplete forms may delay enrollment in benefits

Section 1: Confirm the request being made – *indicate request and complete applicable sections*

☐ New Hire / Rehire / Open Enrollment *(see section 2, 4, 7)*
☐ Waiving Coverage *(see section 2, 5, 7)*
☐ Change to Existing / Qualifying Event *(see section 2, 3, 7)*
☐ Cobra / Cal-COBRA *(see section 2, 3, 5, 7)*

Section 2: Employee Information – *must be completed for all enrollments, waivers, or changes*

Last Name *(print)*: _____ First Name: _____ Hire/Rehire/Qualifying Event Date: _____

Street Address *(no PO Box)*: _____ Home/Cell Phone: _____ # of hours worked per week: _____

City: _____ State: _____ Zip: _____ Annual Salary: _____ Job Title / Occupation _____

(Life/LTD enrollments only. Additional Beneficiary Designation Form will be required)

Section 3: Change to Existing Enrollment – *subscriber/dependent change/termination*

This change applies to: ☐ Medical ☐ Dental ☐ Vision ☐ Life/LTD Effective Date of Change: _____

Requested change/qualifying event: ☐ Address change ☐ Name change – former name: _____

☐ Add Dependent(s) – due to: *(complete section 4)* ☐ Birth ☐ Adoption ☐ Loss/Gain of other coverage ☐ Marriage/Domestic Partnership

☐ Terminate Subscriber and/or Dependent(s) – due to: *(complete section 4 & 5)* ☐ Subscriber's employment terminated ☐ Reduction of Subscriber's work hours

☐ Gain other coverage/Medicare ☐ Divorce/Domestic Partner Separation ☐ Death

Section 4: Elections – *select from only the coverages offered by your employer*

Please note that Social Security numbers for *ALL* family members are required. Please list yourself and all eligible family members to be enrolled by filling out the requested information. If your dependent(s) have a different address or phone number, please attach that information along with your enrollment form. Attach additional sheets if you have more than four dependent children.

	Last Name	First Name	MI	Social Security #	DOB *(mm/dd/yy)*	Age	Sex *(M/F)*	Totally Disabled *(Y/N)*	**Medical Plan Selected *(indicate plan name)*:**	Dental	Vision
Self:									☐ Waive ☐ Cover HMO provider #: _____	☐ Cover ☐ Waive	☐ Cover ☐ Waive
Spouse / D.P.									☐ Waive ☐ Cover HMO provider #: _____	☐ Cover ☐ Waive	☐ Cover ☐ Waive
Child:									☐ Waive ☐ Cover HMO provider #: _____	☐ Cover ☐ Waive	☐ Cover ☐ Waive
Child:									☐ Waive ☐ Cover HMO provider #: _____	☐ Cover ☐ Waive	☐ Cover ☐ Waive
Child:									☐ Waive ☐ Cover HMO provider #: _____	☐ Cover ☐ Waive	☐ Cover ☐ Waive
Child:									☐ Waive ☐ Cover HMO provider #: _____	☐ Cover ☐ Waive	☐ Cover ☐ Waive

All forms MUST be completed within 31 days of the qualifying event. Forms may be submitted via mail, fax or preferably secure email to:

Banyan Administrators, LLC Managers for the CalCPA Health Programs at 1215 Manor Drive Suite 200, Mechanicsburg, PA 17055 | Fax 877-237-4519 | calcpahealth@calcpahealth.com

CalCPA Health

Employee Enrollment / Change Form

Firm Name: _____

Client Code *(six digit #)*: _____

Illegible or incomplete forms may delay enrollment in benefits

Section 5: COBRA / Cal-COBRA – *to be completed by employer and initial by applicant applying for COBRA/Cal-COBRA coverage*

Applying for: ☐ COBRA ☐ Cal-COBRA Reason for COBRA/Cal-COBRA coverage: _____

COBRA qualifying event date: _____ COBRA begin date: _____ COBRA end date: _____

Cal-COBRA qualifying event date: _____ Cal-COBRA begin date: _____ Cal-COBRA end date: _____

Section 6: Waiving Coverage – *complete this section ONLY if you wish to voluntarily decline coverage offered to you AND/OR a family member(s)*

I hereby decline/terminate coverage for:

☐ Medical Plan Coverage ☐ Myself ☐ Spouse ☐ Children

☐ Dental Plan Coverage ☐ Myself ☐ Spouse ☐ Children

☐ Vision Plan Coverage ☐ Myself ☐ Spouse ☐ Children

Reason for declining coverage:

☐ Employee enrolled in a group Kaiser HMO offered by Employer

☐ Insured under another insurance plan

☐ Employee/Spouse covered by Medicare – *please include copy of current ID Card*

ONLY SIGN IF YOU ARE DECLINING COVERAGE. *Your employer will keep a copy of this declination on file. I acknowledge that the available coverages have been explained to me by my employer and I have every right to apply for coverage. I have been given the chance to apply for this coverage and have voluntarily decided not to enroll myself and/or my dependent(s). By declining this group coverage (unless employee and/or dependents have coverage elsewhere), I acknowledge that my dependents and I may have to wait until the next open enrollment to be enrolled in the group plan(s).*

Employee Signature: _____ **Date:** _____

Section 7: Please read carefully, sign and date – *Employees MUST sign below*

The Trust and the Service Administration are authorized to obtain and release medical information in compliance with the Medical information Act. Section 56 et seq. of the California Civil Code and the Insurance Information and Privacy Protection Act, Section 791 et seq. of the California Insurance Code. I hereby authorize any physician, healthcare practitioner, hospital, clinic or other medical or medically related facility to furnish to an agent, designee, or representative of the Service Administrator or of the Trust any and all records pertaining to medical history, services rendered, or treatment given to anyone enrolled hereunder or added hereafter for purposes of review, investigation, or evaluation of an application or a claim. I also authorize the Trust and the Service Administrator and their affiliates, or their agents, designees, or representatives to disclose to a hospital or healthcare service plan, self-insured plan, or insurer any such medical information obtained if such disclosure is necessary to allow the processing of any claim. This authorization also permits disclosure of any such medical information to my employer, the Trust or the Service Administrator for purposes of utilization review or financial audit. This authorization shall become effective immediately and shall remain in effect as long as necessary to enable the Service Administrator and its affiliates to process claims or conduct a utilization review or financial audit. I understand that the effective date of coverage is based on my firm's established waiting period and is subject to approval by the Service Administrator. I understand that I am responsible for a greater portion of my medical costs when I use a non-participating hospital, physician, pharmacy or other provider. If applicable, I authorize my employer to deduct the required contribution from my wages. I agree that any dispute between myself (and/or any family member) and the Trust shall be resolved by binding arbitration, as is more completely set forth in the applicable CalCPA Health Plan Document, if the amount in dispute exceeds the jurisdictional limit of the Small Claims Court, and not any lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. Under this coverage, both the member and the Trust are giving up the right to have any dispute decided in a court of law before a jury. I agree that if I, or a member of my family, is injured through the act of omission of any person (a third party), the Trust shall be subrogated to all rights of me and my family members to recover against such third party as a result of such injury to the extent that the Trust pays benefits under the CalCPA Health Plan for covered services or otherwise related to such injury. At the request of the Trust, I hereby agree to execute in writing (i) providing for the reimbursement of the Trust to the extent of benefits provided immediately upon collection of damages for such injury by me or a family member, whether by action at law settlement or otherwise; and (ii) providing the Trust with a lien to the extent of benefits provided under the plan upon the claim against the third party. The lien may be perfected by the Trust and/or filed with the third party or the court. I have read and understand the provisions outlined in this form. All information on this form is correct and true. I understand that it is the basis on which coverage may be issued under the plan. Any misstatements or omissions may result in future claims being denied and/or the policy being rescinded. I understand that I am entitled to a copy of this signed authorization for my files.

Definitions: The term "Trust" means the Group Insurance Trust of the California Society of Certified Public Accountants. "Trust" also includes the Board of Trustees of the Trust, the Service Administrator and their respective employees, officers and agents. "Service Administrator" means BC Life and Health Insurance Company or any replacement appointed by the Board of Trustees. "Member" means an enrolled employee, spouse, domestic partner, or dependent.

Employee Signature: _____ **Firm Administrator Signature:** _____

Date: _____ **Date:** _____