CalCPA Health
Health plans for CPAs since 1959

Employee Enrollment Form

To be completed by each employee becoming a member of a medical, dental or vision plan, applying for COBRA coverage, or waiving coverage.

Type of Enrollment:

New Enrollment **Re-Hire** **Re-Enrollment** **Late Enrollment** **COBRA**

Firm Name: ______________________ **Client Code:** ______________ six digit number

Date of Hire/Rehire (mm/dd/yy) : _________

Requested Effective Date: ______________

Number of hours worked per week: ______

Personal Information - *Please complete requested information*

Last Name (Print)	First	MI	
Home Phone/Cell Phone	Business Phone	Email	
Street Address (not PO Box)	City	State	Zip	Date of Birth

Elections (REQUIRED INFORMATION)

Employee and Family information - Please Note: Under the Medicare, Medicaid and State Children's Health Insurance Plan Extension Act of 2007 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. Check the Totally Disabled Yes box only if the individual's condition prohibits him/her from working or performing daily activities.

Medical Plan Selected: ____________________ **(Please indicate plan name)**

Relationship	Last Name	First Name	MI	SSN	DOB	Age	Gender	Full-Time Student	Totally Disabled	PMG/IPA Number (if applicable) *	Medical Plan Selected: Cover/ Waive	Dental: Cover/ Waive	Vision: Cover/ Waive
Self							□ M □ F		□ Y □ N		□ Cover □ Waive	□ Cover □ Waive	□ Cover □ Waive
Dependents													
Spouse							□ M □ F		□ Y □ N		□ Cover □ Waive	□ Cover □ Waive	□ Cover □ Waive
Domestic Partner							□ M □ F		□ Y □ N		□ Cover □ Waive	□ Cover □ Waive	□ Cover □ Waive
Child							□ M □ F	□ Y □ N	□ Y □ N		□ Cover □ Waive	□ Cover □ Waive	□ Cover □ Waive
Child							□ M □ F	□ Y □ N	□ Y □ N		□ Cover □ Waive	□ Cover □ Waive	□ Cover □ Waive
Child							□ M □ F	□ Y □ N	□ Y □ N		□ Cover □ Waive	□ Cover □ Waive	□ Cover □ Waive
Child							□ M □ F	□ Y □ N	□ Y □ N		□ Cover □ Waive	□ Cover □ Waive	□ Cover □ Waive
Child							□ M □ F	□ Y □ N	□ Y □ N		□ Cover □ Waive	□ Cover □ Waive	□ Cover □ Waive

***If medical selection is the HMO Advantage 100 or HMO Value 80, you must select a Primary Medical Group (PMG) or an Independent Practice Association (IPA): PMG or IPA Medical Office Number. Please refer to Anthem Blue Cross Provider Directory or www.anthem.com for PMG or IPA Number.**

<u>Other Medical Coverage for Each Enrolling Employee and Dependents: All questions must be answered.</u>

Do any persons on this application intend to continue other Group coverage if this application is accepted? □ Y □ N

If Yes, Name of person ______________________ Insurance Co. ____________________ Policy # ________________

Would you prefer to receive vital documentation regarding CalCPA Health in a language other than English? □ Y □ N If Yes, what language: ____________________

Please return completed form via Fax: 877-237-4519 or Email: calcpahealth@fnrm.com

Mail: Banyan Administrators, LLC 1215 Manor Drive Ste 200 Mechanicsburg, PA 17055

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Coverage Declination - *Please complete if you are declining or refusing any coverage for yourself and/or eligible family members*

Medical Plan Coverage - I decline coverage for: ☐ Myself ☐ Spouse ☐ Children

Dental Plan Coverage - I decline coverage for: ☐ Myself ☐ Spouse ☐ Children

Vision Plan Coverage - I decline coverage for: ☐ Myself ☐ Spouse ☐ Children

Reason for Declining Health plan Coverage:

☐ Employee covered as a dependent under spouse's employer medical plan Carrier Name and ID# _____ (Please include copy of current ID card)

☐ Employee covered by Champus or Champva (Please include copy of current ID card)

☐ Employee/spouse covered by Medicare (Please include copy of current ID card)

☐ Employee enrolled in a group HMO Carrier Name _____ (Please include copy of current ID card)

☐ Employee covered by an individual policy

☐ 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. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage.

By declining this group medical coverage (unless employee and/or dependent have group medical coverage elsewhere), I acknowledge that my dependents and I may have to wait 12 months from the date of this application to be enrolled in this group medical plan and that pre-existing conditions will not be covered for 6 months.

Notwithstanding the foregoing, if you are declining enrollment for yourself and dependents because of other health insurance coverage, you may in the future be able to enroll yourself or dependents in this plan, provided you request enrollment within 31 days after 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 you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

Please sign if you are declining coverage for yourself and/or dependents. ***Your employer will keep a copy of this declination on file.***

Employee Signature: _____ Date: _____ Employer: _____ Group Number _____

COBRA Information - *To be completed by employer and initialed by applicant when applying for COBRA coverage*

For an Employee: Is Qualifying Event ☐ Voluntary ☐ Involuntary

☐ Termination ☐ Reduction in employee's work hours ☐ Benefits terminated or reduced within one year before or after a retired employee's employer filed for bankruptcy under Chapter 11

For a Family Member:

☐ Death of Employee ☐ Divorce or legal separation from employee ☐ Loss of dependent child eligibility status ☐ Employee becomes entitled to Medicare

☐ Benefits terminated or reduced within one year before or after a retired employee's employer filed for bankruptcy under Chapter 11

Other : If enrolled from a prior carrier's COBRA coverage, please indicate the qualifying event, applicable dates and stipulated information below:

Date of Qualifying Event _____ Date of Loss of Coverage _____ Date When Continued Coverage Ends _____ Date Notice Given _____

Applicant's Initials _____ Group Policyholder Representative Signature and Title _____ Telephone Number _____

Definitions - *Please Read*

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

Effective Date - *Please Read*

The effective date of coverage is based on your firm's established waiting period and is subject to approval by the Service Administrator

Non-Participating Provider - *Please read and initial*

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.

Applicant's Initial _____

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Authorization to Obtain or Release Medical Information - *Please read, sign and date*

The Trust and the Service Administrator 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 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 I have a right to receive a copy of this authorization.

Employee Signature: _____ Date: _____

Applicant must sign and date this medical information authorization

Deduction Authorization - *Please read and initial*

If applicable, I authorize my employer to deduct the required contribution from my wages.

Initial: _____

Arbitration Agreement - *Please read and initial*

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.

Initial: _____

Subrogation for Injury Recoveries - *Please read and initial*

I agree that if I, or a member of my family, is injured through the act of omission of another 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 a writing (i) providing for the reimbursment 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.

Initial: _____

Please Note:

Proof of prior coverage may be required by Anthem Blue Cross to waive the six-month pre-exisiting condition clause as of applicant's enrollment date. Acceptable forms of proof include a HIPAA coverage certificate, copy of I.D. Card, copy of payroll stub showing medical coverage deduction, or copy of most recent medical premium bill.

Signature of Understanding - *Please read, sign and date*

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 an/or the policy being rescinded. I understand that I am entitled to a copy of this signed authorization for my files.

Signature of Employee: _____

Date: _____

Signature of Employee's Spouse/Domestic Partner (if applying for coverage) _____

Date: _____

Signature of Firm Administrator: _____

Date: _____

Rev. 11/2010