OnePoint Health/Vision Enrollment/Change Request

OnePoint
Comprehensive HR Solutions

OnePoint HRO, LLC		Control	Suffix	Account	Plan Number

A. Type of Activity - Employee Completes Sections A - E. Please Print Clearly.

Instructions:	Enrollment	Change – *check all that apply*	Remove or Terminate – *Check all that apply*	Waive Medical Coverage	Waive Vision Coverage
Refer to the instructions on the back before completing this form. You must complete this application in full or it will be returned to you resulting in a delay in processing. You are solely responsible for its accuracy and completeness.	New Enrollment Effective Date _______/_______/_______ Date of Hire _______/_______/_______	☐ Add Spouse ☐ Add Dependent Child ☐ Name Change ☐ Other ☐ Change Plan ☐ COBRA Election Date of Event ______/______/______ Reason _______________	☐ Remove Spouse ☐ Remove Dependent Child ☐ Employee Withdrawal/Termination Effective Date: ______/______/______ Reason: ___________________________	☐ Other group health insurance ☐ Medicare Coverage (claim #_________) ☐ Not interested at this time, no other ins	☐ Other group vision insurance ☐ Not interested at this time, no other ins ☐ Other: _______________

B. Employee Information

Social Security Number	Gender M ☐ F ☐	Date of Birth	First Name Last Name	
Home Address	Apt. No		City, State	Zip Code
Home Telephone	Employer Name			

C. Plan Options

Aetna Plans

- ☐ 1. Value Plan
- ☐ 2. HDHP 5000/80%
- ☐ 3. HDHP 3000/90%
- ☐ 4. HMO 2500/70%
- ☐ 5. HMO 1500/80%
- ☐ 6. MC OA 3000/70%
- ☐ 7. MC OA 2000/80%
- ☐ 8. MC OA 3000/100%
- ☐ 9. MC OA 1000/80%
- ☐ 10. MC OA 500/80%
- ☐ 13. Whole Hlth 1000/70%
- ☐ 14. Whole Hlth 2750/80%
- ☐ Aetna Vision – Low Plan
- ☐ Aetna Vision – High Plan

Kaiser Plans

- ☐ 1. Kaiser HDHP 3000/90%
- ☐ 2. Kaiser DHMO 5000/60%
- ☐ 3. Kaiser DHMO 3000/90%
- ☐ 4. Kaiser DHMO 1500/80%
- ☐ 5. Kaiser DHMO 1000/80%

D. Individuals Covered – List Individuals for whom you are adding/change/removing coverage.

MEDICAL (A)dd (C)hange (R)emove	VISION (A)dd (C)hange (R)emove	First Name Last Name	Date of Birth	Gender M F	Social Security Number (if dependent has no SSN, write "None")	Handicapped
		Employee	*To be completed in Section B*			N/A
		Spouse		☐ ☐		Yes ☐
		Child		☐ ☐		Yes ☐
		Child		☐ ☐		Yes ☐
		Child		☐ ☐		Yes ☐

Does any dependent listed above live at a different address than the employee? If yes, who and what address?

Explain the circumstances:

E. Employee Signature

I certify that all information supplied in this form is true and complete to the best of my knowledge and/or belief. I have read and agree to the Conditions of Enrollment on the reverse side of this Enrollment/Change Request form.	Employee Signature – *Required* X	
	Date / /	Email Address

Instructions

Employer - Complete the Employer Group Information at the top of the form.

Employee - Complete Sections A - E.

Section A -Type of Activity:
- Check box(es) indicating reason(s) for submitting this Enrollment Change Request
- Provide Effective Date(s) and Date of Event(s) where requested

Section B - Employee Information: Complete all information in order for your Enrollment/Change Request to be processed.

Section C - Plan Options:
- Select only an option(s) offered by your employer.
- Check one Health Plan Option box and the Aetna Vision Box to enroll

Section D - Individuals Covered:
- Add/Change/Remove • Use "A", "C. or "R" to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the name(s) of your dependent(s), if applicable. Indicate
- Gender, Birthdate, and Social Security Number for each individual listed.
- If a dependent is Handicapped and financially dependent, check "Yes" and provide proof of handicapped status from the attending physician.

Section E - Employee Signature:
- Complete this section for all new enrollments or coverage changes.
- Employee must sign and date the Enrollment/Change Request in order for it to be processed.