COBRA BENEFIT ENROLLMENT / CHANGE FORM

(PLEASE UPDATE ALL OF YOUR PERSONAL INFORMATION)

2017 Annual Enrollment

**□ Change □ Add □ Drop**

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| **SECTION I: PARTICIPANT PERSONAL INFORMATION** | | | | | | | | | | | | |
| Employee Name: Last, First, M.I. | | | | | Social Security No. | | | Employee ID | | | **FOR OFFICE USE** | |
| Date Form Received: \_\_\_\_/\_\_\_\_/\_\_\_\_\_  Date Form Processed: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ | |
| Hire Date | Marital Status | Gender | | | Birth Date | | Personal Email | | | |
| Home Address: Street City State Zip | | | | | | | | Home Phone No. | | |
| SECTION II: HEALTHCARE ENROLLMENT / CHANGES (NOTE: Refer to the 2017 Benefits Resources Guidebook for detailed information regarding the following plans.) | | | | | | | | | | | |  |
| Medical Plan **I elect option: □ Low Deductible □ KelseyCare**  **□ High Deductible**  □ Employee Only  □ Employee + Spouse □ Employee + Child(ren)  □ Employee + Family □ Decline / Cancel Coverage | | | Dental Plan **I elect: □ HMO □ PPO**  □ Employee Only  □ Employee + Spouse □ Employee + Child(ren)  □ Employee + Family □ Decline / Cancel Coverage | | | | | | Vision Plan **I elect: □ Vision**  □ Employee Only  □ Employee + Spouse □ Employee + Child(ren)  □ Employee + Family □ Decline / Cancel Coverage | | | |
| SECTION III: COVERED DEPENDENTS (For additional dependents, please add them on a separate sheet of paper and attach to this form.) | | | | | | | | | | | | |
| Name of Dependent (s)  (Last, First, M.I.) | | | | Gender | | Date of Birth | Social Security No. | | | Relationship | | |
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| **SECTION IV: OTHER HEALTHCARE COVERAGE** | | | | | | | | | | | | |
| Do you or your dependents have other health insurance under a group plan or Medicare? If yes, contact CIGNA at 800.244.6224 and provide other coverage information | | | | | | | | | | | | |
| **SECTION V: IMPORTANT MESSAGE** | | | | | | | | | | | | |
| 1. This enrollment does not guarantee benefits coverage for newly enrolled or re-enrolled dependents. Final eligibility will be determined by the Employee Benefits Department.   Dependent eligibility documentation for newly or re-enrolled dependents must be submitted no later than ***January 23, 2017***via fax or mail to:  **Attention:** Employee Benefits Department  **Fax:** 713-440-5575  **Mail:** 2525 Holly Hall  Houston, TX 77054   1. Once submitted, this election will take effect on March 1, 2017. | | | | | | | | | | | | |
| I understand that it is my responsibility to notify Harris Health System within 31 days of a family status change. I understand that my medical, dental, and vision benefits plans require that my election remain unchanged for the entire year unless I have a qualified family status change. I hereby certify the above information to be true to the best of my knowledge and the dependents for which I am requesting coverage are eligible as defined by the Harris Health System eligibility rules. **TERMS & CONDITIONS:** Your participation in the Harris Health System Health & Welfare plans and coverages is, in all events, subject to the terms and conditions of the actual plan documents, insurance agreements and applicable laws, any of which may be amended from time to time. Your attention is particularly directed to the following items: **FRAUD**: 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 false or deceptive statements, may be guilty of insurance fraud. **MISREPRESENTATION**: Penalties may include immediate and permanent loss of Harris Health System benefits. By signing below, I acknowledge and agree to all of the terms and conditions outlined within this document. | | | | | | | | | | | | |

Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_