

Small Group Employee Election Form

Enrollment/Change/Cancel

Company Name:	Company ID:	Business Phone:
----------------------	--------------------	------------------------

1. ACTION (Complete Applicable box below)

New Enrollment/Addition (check one): <input type="checkbox"/> New Hire - Date of hire __/__/____ <input type="checkbox"/> Open Enrollment/Re-enrollment <input type="checkbox"/> Status Change (PT to FT) on __/__/____ <input type="checkbox"/> Birth - enter child's name and date of birth below <input type="checkbox"/> Marriage - Date of Marriage __/__/____ <input type="checkbox"/> Adoption (attach legal documentation) <input type="checkbox"/> Other (describe): -----	Cancellations (check all that apply): <input type="checkbox"/> Cancel all coverage <input type="checkbox"/> Cancel dependents listed below (in Section 4) <div style="border-left: 1px solid black; padding-left: 5px; margin-left: 20px;"> <input type="checkbox"/> Employee Terminated <input type="checkbox"/> Moved out of service area <input type="checkbox"/> Death <input type="checkbox"/> Divorce <input type="checkbox"/> Dependent reached maximum age <input type="checkbox"/> Other (describe): ----- </div>	Change (check all that apply): <input type="checkbox"/> Address (enter new in Section 2) <input type="checkbox"/> Name (enter new in Section 2 or 4) <input type="checkbox"/> COBRA or State Continuation <input type="checkbox"/> Change in other Health Insurance Information (Complete Section 6) <input type="checkbox"/> Other (describe): -----
Requested Effective Date of Enrollment: __/__/____	Requested Effective Date of Cancellation: __/__/____	Requested Effective Date of Change: __/__/____

2. EMPLOYEE INFORMATION

Social Security Number:	First Name:	M.I.:	Last Name:	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner
Street Address:	City:	State:		Zip code:
Email	Date of Birth: __/__/____		Sex:	County:
Occupation:	Date of Hire: __/__/____	Employment Status: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time		Hours Worked Per Week:

3. COVERAGE SELECTION (Please check one)

<input type="checkbox"/> Individual <input type="checkbox"/> Individual and adult	<input type="checkbox"/> Individual and children <input type="checkbox"/> Individual and family (which covers the Subscriber, adult, and children)
--	---

4. DEPENDENTS (List all dependents to be covered. Use additional sheet if needed.)

	Last Name	First Name	MI	Social Security #	DOB <small>(mm/dd/yyyy)</small>	Sex	Disabled	[Primary Care Provider Name (Only required if you are selecting an HMO or HPN plan)] <small>Only will be displayed if a group offers an HMO or HPN plan</small>
Employee								
Partner/Spouse								
Dependent 1								
Dependent 2								
Dependent 3								
Dependent 4								
Dependent 5								

5. PLAN SELECTION [Please select one]

- | | |
|--|---|
| <input type="checkbox"/> Evergreen Health HMO Open Access Bronze 4250 [HGBH00.17F] | <input type="checkbox"/> Evergreen Health POS Gold HSA 1350 [PGGH00.17F] |
| <input type="checkbox"/> Evergreen Health HMO Open Access Gold HSA 1350 [HGGH00.17F] | <input type="checkbox"/> Evergreen Health POS Gold Plus 1500 [PGGPX00.17F] |
| <input type="checkbox"/> Evergreen Health HMO Open Access Gold Plus 1500 [HGGPX00.17F] | <input type="checkbox"/> Evergreen Health POS Platinum 500 [PGPX00.17F] |
| <input type="checkbox"/> Evergreen Health HMO Open Access Platinum 500 [HGPX00.17F] | <input type="checkbox"/> Evergreen Health HMO National Silver HSA 2000 [HGSHN0.17F] |
| <input type="checkbox"/> Evergreen Health HMO Open Access Silver HSA 2000 [HGSH00.17F] | <input type="checkbox"/> Evergreen Health HMO National Silver Plus 3500 [HGSPXN0.17F] |
| <input type="checkbox"/> Evergreen Health HMO Open Access Silver Plus 3500 [HGSPX00.17F] | <input type="checkbox"/> Evergreen Health Select Platinum 500 [NGPX00.17F] |
| <input type="checkbox"/> Evergreen Health POS Bronze 4250 [PGBH00.17F] | <input type="checkbox"/> Evergreen Health Select Gold 1500 [NGGX00.17F] |
| <input type="checkbox"/> Evergreen Health POS Silver HSA 2000 [PGSH00.17F] | <input type="checkbox"/> Evergreen Health Select Silver 5150 [NGSX00.17F] |
| <input type="checkbox"/> Evergreen Health POS Silver Plus 3500 [PGSPX00.17F] | |

Only plans offered by the group will be displayed

6. OTHER INSURANCE INFORMATION

Will you or your dependents continue health coverage with another insurer?

Yes No

Other Health Insurer Name:

Who is covered? Self Spouse/Partner Dependents All

Plan or Carrier Name:

Policy # -----

Effective Date: __/__/____ **Term Date:** __/__/____

7. ELECTRONIC COMMUNICATION CONSENT

Evergreen Health Cooperative Inc. wants to help you manage your health care information and protect the environment by offering you the option of electronic communication.

Instead of paper delivery, you can receive electronic notices about your Evergreen Health Cooperative Inc. coverage through email and/or text messaging by providing your email address and/or cell phone number and consent below.

Electronic notices regarding your Evergreen Health Cooperative Inc. coverage include, but are not limited to:

- Explanation of Benefits
- Reminders
- Notice of HIPAA Privacy Practices
- Certification of Creditable Coverage

You may also receive information on programs related to your existing products and services along with new products and services that may be of interest to you.

Please note: you may change your email and consent information anytime by logging into the member portal or by calling the customer service phone number on your ID card. You can also request a paper copy of electronic notices at any time by calling the customer service phone number on your ID card.

I understand that to access the information provided electronically through email, I must have the following:

- Internet access;
- An email account that allows me to send and receive emails

I understand that to receive notices through text messaging,

- A text messaging plan with my cell phone provider is required; and
- Standard text messaging rates will apply.

By checking this box, I hereby agree to electronic delivery of notices, instead of paper delivery by:

- Email and cell phone text messaging (only if you include your cell phone number below)

Name	Email Address	Cell Phone #
Employee		{ }
Spouse/Partner Name:		{ }
Eligible Dependent Name(s) (if 16 or older)		{ }
		{ }
		{ }
		{ }
		{ }
		{ }

8. SIGNATURES

CERTIFICATION: I hereby apply, on behalf of myself and each dependent listed above, for coverage(s) indicated and certify on behalf of my eligible family dependents and myself that the answers contained in this Election Form are complete and accurate to the best of my knowledge. I further certify that the dependents listed above are eligible to enroll in the plan(s) selected. I have indicated in this Election Form, if required, what benefit plan(s) or provider(s) I have selected. On behalf of my eligible family dependents and myself, I agree to all of the terms and conditions of the group contract with Evergreen Health Cooperative Inc. (Evergreen Health) under which I wish to enroll for coverage.

I agree that no coverage will be effective until the date specified by Evergreen Health, after this Election Form has been accepted by Evergreen Health. If accepted, coverage will be provided according to the terms and conditions of the benefit plan(s) between Evergreen Health and my employer. I agree to be bound by the benefit plan(s) of which this form will become part. I also agree to pay current and future charges for coverage(s) provided in excess of any employer contribution. I also understand that failure to enter accurate information may result in termination of my coverage.

Evergreen Health may rescind my coverage if I have performed an act, practice, or omission constitutes fraud or I have made an intentional misrepresentation of material fact. Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. Evergreen Health will provide 30-days advance notice in the case of fraud or intentional misrepresentation of material fact. **If you have any questions concerning the benefits and services provided by or excluded under this agreement, please contact a Service Representative before signing this Election Form.** Coverage shall become effective solely upon final approval by Evergreen Health and not from the collection of premiums.

Employee signature:	Date: __/__/____
Employer signature:	Date: __/__/____

NON-DISCRIMINATION NOTICE

Evergreen Health does not view or treat people differently because of their race, color, national origin, sex, age or disability. Evergreen Health provides assistance free of charge to people with disabilities or whose primary language is not English. These services include aids for people with disabilities, language assistance through interpreters and information written in other languages. If you need any of these services, please call us at 1-855-884-1400.

If you believe that Evergreen Health has failed to provide these services or discriminated on the basis of race, color, national origin, age, disability, or sex, you can file an internal Civil Rights grievance directly with Evergreen Health by contacting: Civil Rights Coordinator, 3000 Falls Rd, Suite 1, Baltimore, MD 21211. You may also contact us by telephone at 443 475 0990; or by email at civilrightscoordinator@evergreenmd.org

You can also file a Civil Rights complaint directly with the U.S. Dept. of Health and Human services, Office for Civil Rights, online, by phone, or by mail at:

- Online:** <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>.
Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>
- Phone:** Toll-free 1-800-368-1019, 800-537-7697 [TDD]
- Mail:** U.S. Dept. of Health and Human Services.
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

<p>French ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-884-1400.</p>	<p>Spanish ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-884-1400.</p>
<p>Amharic ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-855-884-1400.</p>	<p>Arabic ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-884-1400</p>
<p>Yoruba AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 1-855-884-1400.</p>	<p>Igbo Asusu Ige nti: O buru na asu lbo asusu, enyemaka diri gi site na call 1-855-884-1400.</p>
<p>Portuguese ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-884-1400.</p>	<p>Tagalog PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-884-1400.</p>
<p>Vietnamese CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-884-1400.</p>	<p>Haitian Creole ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-884-1400</p>
<p>Chinese 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-884-1400。</p>	<p>Russian ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-884-1400.</p>
<p>Hindi ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएँ उपलब्ध हैं। 1-855-884-1400</p>	<p>Korean 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-884-1400.</p>
<p>Bassa Dè dè nià ke dyéde gbo: Ɔ jũ ké m̄ [Bàsɔ̀̀-wùd̄̀-̀̀po-nyò] jũ ní, nìí, à wuɖu kà kò d̄̀ò po-poò f̄̀èim m̄ gbo kpáa. Dá 1- 855 – 884 -1400.</p>	<p>Urdu خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب کریں 1-855-884-1400 ہیں۔</p>
<p>Farsi توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-855-884-1400 فراهم می باشد.</p>	<p>Gujarati સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-855-884-1400.</p>