BENEFITS ENROLLMENT / CHANGE FORM

P.O. Box 6927, Columbia, SC 29260
TELEPHONE #: (803) 462-0151 / (800) 768-4375 FAX #: (803) 870-8852

We make Benefits Better.

ENROLLMENT REASON: NEW ENROLLMENT ☐ CHANGE ☐
(For PAI use only) NO LOSS NO GAIN: EE ☐ DEP ☐ NONE ☐

(Check as applicable)
PAYROLL DEDUCTION: EMPLOYEE ☐ DEPENDENT ☐

Employee Information

EMPLOYER:	GROUP #:	LOCATION #:
EMPLOYEE NAME:	SOCIAL SECURITY #:	
ADDRESS: CITY:	STATE:	ZIP CODE:
DATE OF BIRTH:	GENDER: M ☐ F ☐	MARITAL STATUS: SINGLE ☐ MARRIED ☐ DIVORCED ☐
EMAIL ADDRESS:	TELEPHONE #:	
DATE EMPLOYED:	COVERAGE EFFECTIVE DATE:	WAITING PERIOD (days): 30 ☐ 60 ☐ 90 ☐

Healthcare Coverage

COVERAGE SELECTION	***Medical***	***Dental***	***Vision***
SINGLE	☐	☐	☐
EMPLOYEE & SPOUSE	☐	☐	☐
EMPLOYEE & 1 ☐ 2 ☐ 3+ ☐ children	☐	☐	☐
FAMILY [EMPLOYEE, SPOUSE & CHILD(REN)]	☐	☐	☐

Dependent Coverage

PLEASE LIST ANY DEPENDENTS (AGE 19 AND OVER) WHO ARE ELIGIBLE FOR THEIR OWN EMPLOYER SPONSORED MEDICAL HEALTH INSURANCE.

NAME: ______________________ RELATIONSHIP: ______________
NAME: ______________________ RELATIONSHIP: ______________
NAME: ______________________ RELATIONSHIP: ______________
NAME: ______________________ RELATIONSHIP: ______________
NAME: ______________________ RELATIONSHIP: ______________

Dependent Information

	Last Name	First Name	Middle Initial	Social Security #	Date of Birth *(mm/dd/yyyy)*	Gender
☐ **SPOUSE** ☐ **DOMESTIC PARTNER**						M ☐ F ☐

Address *(if different from employee address above)*

Email address of Spouse/Domestic Partner	Spouse/Domestic Partner Telephone #:

	Last Name	First Name	Middle Initial	Social Security #	Date of Birth *(mm/dd/yyyy)*	Gender
CHILD						M ☐ F ☐

Address *(if different from employee address above)*

Email address of Child	Child Telephone #

	Last Name	First Name	Middle Initial	Social Security #	Date of Birth *(mm/dd/yyyy)*	Gender
CHILD						M ☐ F ☐

Address *(if different from employee address above)*

Email address of Child	Child Telephone #

	Last Name	First Name	Middle Initial	Social Security #	Date of Birth *(mm/dd/yyyy)*	Gender
CHILD						M ☐ F ☐

Address *(if different from employee address above)*

Email address of Child	Child Telephone #

	Last Name	First Name	Middle Initial	Social Security #	Date of Birth *(mm/dd/yyyy)*	Gender
CHILD						M ☐ F ☐

Address *(if different from employee address above)*

Email address of Child	Child Telephone #

IF CHANGING COVERAGE, PLEASE LIST BELOW: EFFECTIVE DATE OF CHANGE:____________________

- ☐ NAME CHANGE FROM:______________________ TO: ______________________
- ☐ SINGLE TO FAMILY (LIST ADDED DEPENDENTS ABOVE.)
- ☐ FAMILY TO SINGLE (LIST DELETED DEPENDENTS ABOVE.)
- ☐ ADD DEPENDENT(S) (LIST ADDED DEPENDENTS ABOVE.)
- ☐ DELETE DEPENDENT(S) (LIST DELETED DEPENDENTS ABOVE.)

Other Coverage	
	Do you or does any member of your family have other group health, dental or drug coverage, Federal Employees' Program (FEP) or Medicare?
	Yes ☐ No ☐ If YES: ☐ MEDICARE Effective Date:_____ Health Insurance Claim Number (HICN):_____
	A. Family Member's Name: _____ Social Security #:_____
	B. Name of Insurance Company:_____ Policy #:_____ Effective Date:_____
	C. Family Member's Employer:_____
	D. List Names of Covered Person(s): 1_____ 2_____ 3_____ 4_____
	E. Please select each type of service covered by the policy: Hospital ☐ Physician/Medical ☐ Prescription Drug ☐ Dental ☐ Vision ☐

I HEREBY CERTIFY THAT I AM AN ACTIVE FULL-TIME EMPLOYEE. IT IS FURTHER UNDERSTOOD THAT THE ACCEPTANCE OF MY PREMIUM BY MY EMPLOYER AT ANY TIME SHALL NOT OPERATE AS A WAIVER OR ESTOPPEL WITH RESPECT TO ANY PROVISION OF THE GROUP CONTRACT, INCLUDING THE PROVISIONS CONCERNING ME OR MY DEPENDENT'S (S') ELIGIBILITY. I HEREBY CERTIFY THAT THE FOREGOING STATEMENTS, INCLUDING ANY ACCOMPANYING STATEMENTS, ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I HEREBY AUTHORIZE ANY HEALTH PROVIDER OR MY EMPLOYER TO RELEASE ANY RECORDS OR INFORMATION TO PLANNED ADMINISTRATORS, INC. ON MYSELF OR DEPENDENT(S). A COPY OF THIS RELEASE IS AS VALID AS THE ORIGINAL. I HEREBY AUTHORIZE MY EMPLOYER TO DEDUCT THE REQUIRED PREMIUM CONTRIBUTIONS, IF ANY, FROM MY PAYROLL EARNINGS.

Employee Signature_____ Date_____

SIGN BELOW IF YOU <u>DO NOT ELECT</u> TO BE COVERED

I HEREBY CERTIFY THAT I HAVE BEEN OFFERED AN OPPORTUNITY TO BECOME COVERED UNDER THE PLAN SPONSORED BY MY EMPLOYER AND I HAVE DECIDED NOT TO TAKE ADVANTAGE OF THIS OFFER.

Employee Signature_____ Date_____

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice (TDD: 711).

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance by emailing contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥 1-844-396-0188。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đở với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건강보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187로 연락해 주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839 . (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions à propos de ce plan médical, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 1-844-396-0190. (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険 についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره‌ی این برنامه‌ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره‌ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)

Ni da doodago t'áá háída bíká'aná nílwo'ígíí díí Béeso Ách'ą́ąh naa'nilígi háá'ída yí na' ídíł kidgo, nihá'áhóót'i' nihí ká'a'doo wołgo kwii ha'át'íshíį́ bí na'ídołkidígi doo bik'é'azláagóó. Ata' halne'é ła' bich'į' ha desdzih nínízingo, kojį' béésh bee hólne' 1-844-516-6328. (Navajo)