GUARDIAN® Health Net®

Northeast Regional Office
P.O. Box 26050
Lehigh Valley, PA 18002-6050

- **Please Print clearly and in Black or Blue ink**
- **Please Print in Capital Letters only**

Guardian & Health Net Healthcare Solutions
ENROLLMENT/CHANGE FORM - NEW YORK

Planholder Name (Company Name)	Group Plan Number	Division	Class

PLEASE CHECK APPROPRIATE BOX ☐ **Initial Enrollment/Refusal of Coverage** (Complete Sections 1, 4, 5, 6) ☐ **Add Employee/Dependents** (Complete Sections 1, 4, 6) ☐ **Drop/Refuse Coverage** (Complete Sections 2, 5, 6) ☐ **Information Change** (Complete Section 6)

SECTION 1

☐ Add Employee
- ☐ New Hire
- ☐ Previously refused this coverage
- ☐ Loss of Other Coverage (Complete Section 5 if applicable)

☐ Add Spouse
- ☐ Marriage Date ____/____/____
- ☐ Previously refused this coverage
- ☐ Loss of Other Coverage (Complete Section 5 if applicable)

☐ Add Children
- ☐ Newborn
- ☐ Previously refused this coverage
- ☐ Adoption Date ____/____/____
- ☐ Loss of Other Coverage (Complete Section 5 if applicable)

SECTION 2

☐ Drop Employee (Complete Section 4) ☐ Drop Dependents (Complete Section 4)
The date of withdrawal cannot be prior to the date this form is completed and signed.
- ☐ Termination of Employment
- ☐ Retirement
  - Last Day Worked ____/____/____
  - Last Day of Coverage ____/____/____
- ☐ Other _____

SECTION 3

LOSS OF OTHER COVERAGE:
I and/or my dependents were previously covered under another group plan. Loss of coverage was due to:
- Termination of Employment ____/____/____
- Divorce ____/____/____
- Death of Spouse ____/____/____
- Term./Expiration of Coverage ____/____/____

SECTION 4

SELECT COVERAGE(S): Dependents cannot be enrolled for coverage refused by the employee.
- ☐ **Medical** ☐ Employee ☐ Spouse ☐ Child(ren)
- ☐ **Life** ☐ Employee ☐ Spouse ☐ Child(ren)
- ☐ **AD&D** ☐ Employee ☐ Family (includes EE, Sp, Ch)
- ☐ **Dental** ☐ Employee ☐ Spouse ☐ Child(ren)
- ☐ **Vision** ☐ Employee ☐ Spouse ☐ Child(ren)
- ☐ **Long Term Disability** (if applicable choose option)
- ☐ **Short Term Disability** (if applicable choose option)

SELECT COVERAGE OPTIONS: Choose only one option for each coverage.

Medical
- ☐ Charter HMO ☐ Charter POS
- ☐ Outlook EPO ☐ Outlook POS
- ☐ PPO
- ☐ Other _____

Dental ☐ Indemnity ☐ PPO ☐ Buy-Up ☐ Pre-Paid *
* Complete Pre-Paid Office # in Section 6

LTD
- ☐ Buy-Up
- ☐ Flex AbilityGuard $____ (up to 50% of salary)

STD
- ☐ Buy-Up
- ☐ Flex AbilityGuard $____ (up to 50% of salary)

SECTION 5

REFUSE/DROP COVERAGE(S):
- ☐ **Medical** ☐ Employee ☐ Spouse ☐ Child(ren)
- ☐ **Life** ☐ Employee ☐ Spouse ☐ Child(ren)
- ☐ **AD&D** ☐ Employee ☐ Family (includes EE, Sp, Ch)
- ☐ **Dental** ☐ Employee ☐ Spouse ☐ Child(ren)
- ☐ **Vision** ☐ Employee ☐ Spouse ☐ Child(ren)
- ☐ **Long Term Disability** ☐ **Short Term Disability**

I have been offered the above coverages and wish to refuse/drop enrollment for the following reasons:
- ☐ Covered under another insurance plan
- ☐ Other _____ (additional information may be required)

SECTION 6

Add Drop Employee Name: Last | First | MI | Sex M F | Birth Date (MM DD YYYY) | Social Security Number | Pre-Paid Office # (See directory) | PCP Access # (HMO/POS only)

☐ ☐ | | | | | - - | - - | |

Street address | City | State | ZIP

Home Phone: ( ) -

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed

Are you: ☐ A full-time employee ☐ Retired ☐ Other _____ (additional information may be required) Occupation/Job Title:

Number of hours worked per week: Annual Salary (nearest dollar): , , Date of Full Time Hire (MM DD YYYY): - -

Add Drop Dependents Name: Last | First | MI | Sex M F | Student | Birth Date (MM DD YYYY) | Social Security Number | Pre-Paid Office # (See directory) | PCP Access # (HMO/POS only)

☐ ☐ | | | M F | | - - | - - | |
☐ ☐ | | | M F Y N | | - - | - - | |
☐ ☐ | | | M F Y N | | - - | - - | |
☐ ☐ | | | M F Y N | | - - | - - | |
☐ ☐ | | | M F Y N | | - - | - - | |

A) Have you included stepchildren? ☐ Yes ☐ No Are they dependent upon you for support and maintenance? ☐ Yes ☐ No
B) Is this your first eligible child? ☐ Yes ☐ No If "no," please list all eligible children above.

Beneficiary Designation: (include full proper name and relationship) Name: Relationship:

Applicable to Accident and Health Coverages: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or *statement of claim* containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act, which is a crime, *and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.*"
This authorization is valid for 24 months and you may revoke the authorization at anytime by sending a letter to that effect to our address. The information provided on this form is true and correct to the best of my knowledge, and I accept the provisions on the front and back of this form, including the agreement as to the release of information, which I have read and understand.

Signature: _____ Date (MM DD YYYY) - -

COVERAGE:
The Charter HMO and In-Network section of the Charter Point of Service plan is underwritten by Health Net of New York, Inc. and Outlook POS, Outlook EPO and PPO plans are underwritten by Health Net Insurance of New York, Inc. The ancillary lines of coverage and the Out-of-Network portion of the Charter Point of Service plan are underwritten by The Guardian Indemnity Contract Number GP-1-R3-1.0 et al.

REFUSAL OF INSURANCE:
If the plan requires contributions, and I have refused the coverage, the terms for requesting coverage at a later date are as follows: I will not be eligible for the Charter HMO, Charter POS, Outlook POS, Outlook EPO or PPO plans until the next open enrollment period; unless coverage is being discontinued as a result of termination of another plan's coverage, loss of employment, death of spouse, divorce, or unless a court has ordered coverage be provided for a spouse or minor child. To apply for any other coverage, if available, I will be required to furnish, at my own expense, proof of insurability and Guardian reserves the right to reject my request. Proof of insurability does not apply to major medical or dental coverages; however, late entrant penalties may apply.

THE FOLLOWING SPECIAL ENROLLMENT RIGHTS APPLY TO THIS PLAN: If you are declining enrollment for yourself or your dependents because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your 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 that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

AGREEMENT:
I understand the benefits and coverage as summarized in the contract and that these benefits are administered strictly as specified in the contract. I hereby (1) request coverage for the Group program for which I am or may become eligible; (2) authorize my employer to make the necessary deductions for the contributions, if any, required for coverage, or agree that the contribution be added to my dues, if applicable; (3) state that I became an employee on the date stated on this form, and do currently work the number of hours per week stated on this form. I understand that, in order to be accepted for Charter HMO, Charter POS, Outlook POS, Outlook EPO or PPO coverage, my signed and completed application for coverage must be received by Guardian & Health Net within 31 days of my initial eligibility for coverage or within 31 days of the next open enrollment effective date.

I authorize any physician, hospital, insurer or other organization or person having any records or information concerning the health and treatment (including psychiatric and substance abuse and confidential HIV related information) of me and my family member(s) to furnish such records as may be requested by Guardian & Health Net or its authorized representative. A photocopy or digital image of this authorization shall be considered as valid as the original.

"I acknowledge that health care providers may disclose health information about me or my dependents, including information regarding substance abuse or mental/emotional disorders, to Health Net. The plan's use and disclose this information for purposes of treatment, payment and health plan operations, including but not limited to utilization management, quality improvement, disease or case management programs."

I certify that all dependents listed on this form are eligible for coverage under the terms of the contract. I agree to notify Guardian & Health Net and my employer within 31 days when such eligibility ceases. I understand that Guardian & Health Net are not liable to provide coverage for ineligible dependents.

IMPORTANT NOTICE

THE FOLLOWING APPLIES TO OUTLOOK POS, OUTLOOK EPO AND THE PPO PLANS.

Pre-existing Condition Limitation: This plan imposes a pre-existing condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a 6-month period. Generally, this 6-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 6-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy or to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage". Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the pre-existing condition exclusion and creditable coverage should be directed to our Member Services Department at PO Box 8008 Appleton WI 54912 or 1-800-873-4542.

The Pre-existing Condition Limitation notice is being issued to you pursuant to the Federal Health Insurance Portability and Accountability Act of 1996 and reflects the protection afforded under federal law. If the state law applicable to a fully insured Guardian plan is more beneficial to covered individuals as to the length of pre-existing condition limitation and permissible break in coverage, the relevant state law provisions will apply to and be part of your Guardian plan.