SDRMA

SDRMA/PRISM Health
Small Group Benefit Election Form

Employer Name: _____

Employer County:_____

Effective Date: _____

PARTICIPANT ENROLLMENT OR CHANGE – COMPLETE IN FULL

Name (Last, First, MI):	Social Security #:	Birth Date (mm/dd/yy):	☐ Male ☐ Female
Home Street Address: (No P.O. Box) City State Zip		Home Phone:	Work Phone:
Mailing Address: (P.O. Box may be used) City State Zip ☐ Same as Home Address		E-mail Address:	
Medicare: ☐ Part A ☐ Part B	Medicare Claim/HICN/MIB #:		
Occupation/Title:	Date of Hire (mm/dd/yy):	Employee Status: ☐ Full Time ☐ Early Retiree ☐ Part Time ☐ Medicare Retiree	
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Domestic Partner ☐ Legally Separated ☐ Divorced			

TYPE OF ACTION

☐ New Hire Enrollment (list below all dependents to be covered)
☐ New Employer Group
☐ Open Enrollment Election
☐ Other: _____
☐ Name/Address Change
☐ Termination: Last Date Employee Actively Worked: ____/_____/_____ Termination is: ☐ Voluntary ☐ Involuntary
☐ Add or Drop Dependent due to Qualifying Event: QE Event: ____/_____/_____

PARTICIPANT ELECTION

Blue Shield Access + HMO 15 ☐ EE Only ☐ EE + 1 ☐ EE + Family Employee PCP Code: _____ Provider Name:_____ Existing Patient: ☐ Yes ☐ No	**Blue Shield Access + HMO 20** ☐ EE Only ☐ EE + 1 ☐ EE + Family Employee PCP Code: _____ Provider Name:_____ Existing Patient: ☐ Yes ☐ No	**Blue Shield EPO** ☐ EE Only ☐ EE + 1 ☐ EE + Family
Blue Shield Platinum PPO ☐ EE Only ☐ EE + 1 ☐ EE + Family	**Blue Shield Silver PPO** ☐ EE Only ☐ EE + 1 ☐ EE + Family	**Blue Shield Gold PPO** ☐ EE Only ☐ EE + 1 ☐ EE + Family
Blue Shield HDHP 10% ☐ EE Only ☐ EE + 1 ☐ EE + Family	**Blue Shield HDHP 20%** ☐ EE Only ☐ EE + 1 ☐ EE + Family	**HSA (for HDHP Elections Only):** ☐ Yes ☐ No

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DEPENDENT COVERAGE

☐ ADD ☐ TERM	Name (Last, First, MI):	Social Security #:	Birth Date:	☐ Male ☐ Female
Home Street Address: (if different than address above) City,State, Zip			Disabled? ☐ Yes ☐ No	Relation: ☐ Spouse ☐ Domestic Partner ☐ Child
Medicare: ☐ Part A ☐ Part B	Medicare Claim/HICN/MIB #:			
HMO Provider Name (HMO Plans only): Existing Patient: ☐ Yes ☐ No			PCP Code:	

☐ ADD ☐ TERM	Name (Last, First, MI):	Social Security #:	Birth Date:	☐ Male ☐ Female
Home Street Address: (if different than address above) City,State, Zip			Disabled? ☐ Yes ☐ No	Relation: ☐ Child
Medicare: ☐ Part A ☐ Part B	Medicare Claim/HICN/MIB #:			
HMO Provider Name (HMO Plans only): Existing Patient: ☐ Yes ☐ No			PCP Code:	

☐ ADD ☐ TERM	Name (Last, First, MI):	Social Security #:	Birth Date:	☐ Male ☐ Female
Home Street Address: (if different than address above) City,State, Zip			Disabled? ☐ Yes ☐ No	Relation: ☐ Child
Medicare: ☐ Part A ☐ Part B	Medicare Claim/HICN/MIB #:			
HMO Provider Name (HMO Plans only): Existing Patient: ☐ Yes ☐ No			PCP Code:	

☐ ADD ☐ TERM	Name (Last, First, MI):	Social Security #:	Birth Date:	☐ Male ☐ Female
Home Street Address: (if different than address above) City,State, Zip			Disabled? ☐ Yes ☐ No	Relation: ☐ Child
Medicare: ☐ Part A ☐ Part B	Medicare Claim/HICN/MIB #:			
HMO Provider Name (HMO Plans only): Existing Patient: ☐ Yes ☐ No			PCP Code:	

☐ ADD ☐ TERM	Name (Last, First, MI):	Social Security #:	Birth Date:	☐ Male ☐ Female
Home Street Address: (if different than address above) City,State, Zip			Disabled? ☐ Yes ☐ No	Relation: ☐ Child
Medicare: ☐ Part A ☐ Part B	Medicare Claim/HICN/MIB #:			
HMO Provider Name (HMO Plans only): Existing Patient: ☐ Yes ☐ No			PCP Code:	

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PLEASE READ CAREFULLY - SIGNATURE REQUIRED

I declare that the information given on this form is true and complete to the best of my knowledge and belief. I understand that the information I have provided is the basis on which coverage may be issued under these plans. Any misstatements or omissions may result in future claims being denied and/or my coverage(s) being rescinded. I know that if I do not enroll within 30 days of becoming first eligible (or within 31 days of an IRS-qualified change in status) I will have to wait until the next annual enrollment, and may be required to submit evidence of insurability for certain coverage.

My signature below certifies that I have applied for the benefits indicated on this form. I understand that my benefit elections may result in deductions from my pay and authorize my employer to make the required deduction.

By signing below, I acknowledge all of the terms and provisions as described above.

If any changes to this enrollment is deemed a mid-year qualifying event you are responsible to inform your employer within 31 days of the qualifying event date.

Signature:	Date:

DECLINATION OF COVERAGE – SIGNATURE REQUIRED- Complete only if declining medical coverage

I understand that I am eligible for medical coverage through my employer. I waive the right to enroll in the medical plan as offered by my employer for the following persons (please check all that apply below):

☐ Self ☐ Spouse ☐ Child(ren)

Note: Retirees; if coverage is waived at any time then retirees will not be eligible to re-enroll in coverage.

Reason for waiver:

☐ I have my own other group coverage
☐ We are covered through my spouse's employer
☐ My spouse and dependents have other group coverage

I understand that by declining coverage, I will not be eligible for coverage until my employer's next Open Enrollment period unless I qualify for coverage due to a HIPAA qualifying event (including getting married, having a child, or involuntarily losing my other coverage).

Signature:	Date: