



Employee/Dependent Enrollment/Change Form

www.hcgaz.com • 602.417.6755 • 800.247.2289 (outside Maricopa County)
701 E. Jefferson St. • MD 1400 • Phoenix, AZ 85034

A State-Sponsored Health Plan

Business Name _____

Group ID _____ **Member ID H000#** _____

Enrollment Change: Add Employee Business Address Change
 Marital Status Change Name Change
 Add Dependent Add Newborn Add Dependent by Adoption
 Add Dental/Vision (during open enrollment only)

Waiver (Complete Section A Only): Coverage through Spouse Coverage through Parent
 Government Program Individual Coverage

Other _____

COBRA: Enrollment // **Non-COBRA Continuation:** Enrollment (3 month maximum)

Employee Coverage: Termination Reduction of Hours Retirement

Dependent Coverage: Divorce Death of Employee Child Lost Eligibility

HCG USE ONLY

Eff. Date _____ Health Plan _____

Option Code _____ Late Enroll: Yes No

SP Event _____

W/P _____ Renewal _____

Rep. _____

Today's Date _____

DATE

SECTION A ATTENTION: Failure to provide all required documents and make necessary payment in full will result in a delay in processing employee/group request.

Employee Last Name _____ Employee First Name _____ MI _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employee Home Address _____ City _____

County _____ State _____ Zip Code _____ E-mail Address _____

Household Size _____ Annual Household Income (including yourself, spouse, and children) \$ _____

Marital Status: Married Single Divorced Legally Separated Widowed

Occupation/Title _____ Hours/Week _____ Date of Hire _____

SECTION B Are you eligible and/or enrolled in Medicare? No Yes // If enrolled, which part? Part A Part B MA PD

Do you have other Medical Coverage? No Yes Carrier _____

Managed Care Options: Mercy Healthcare Group (available in Gila, Graham, Greenlee, Maricopa, Pima, Pinal, Santa Cruz & Yuma Counties Only)

University Physicians (available in Cochise, Graham, Greenlee, Maricopa, Pima, Pinal & Santa Cruz Counties Only)

Benefit Level: Classic Secure Advantage Active // Deductible \$ _____

SECTION C List all family members who are being added/enrolled.

*Dependents – If full-time student and age 19-23, attach proof verifying full-time student status. If totally disabled prior to age 19, attach proof of disability for eligibility review.

Last Name	First Name	MI	Date of Birth	Gender (m/f)	Relationship	Disabled Adult Dependent*	Full-Time Student*	Primary Care Physician ¹ (Managed Care only)	Existing Patient	Medical	Dental <input type="checkbox"/> EDS ² <input type="checkbox"/> PPO	Vision
Employee									<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse									<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

¹Name of Primary Care Physician (if left blank, a PCP will be assigned to you) _____

²If You are Choosing the EDS Dental Plan, enter your family Dentist's name _____ Dentist code # _____

Please Note: By signing below, I acknowledge that the information provided on all pages of this application is complete and true to the best of my knowledge. I acknowledge that the discovery of facts known to me and not disclosed may result in prosecution and that Healthcare Group coverage for myself and my dependents may be rescinded. I also acknowledge that I will be financially responsible for all costs incurred if I have failed to disclose all required information.

Employee Signature _____ **Date** _____

Employer Signature _____ **Date** _____

INSTRUCTIONS:**Employee/Dependent Enrollment/Change Form****HOW TO ADD A MEMBER (Employee or Dependent):**

Instructions: Employees and their dependents are eligible to receive benefits, during the group's annual open enrollment renewal period, when they have met the Groups' required waiting period (if applicable) as a "Late Enrollee", or during Qualifying Events for Special Enrollment Periods.

Necessary Forms: Employee/Dependent Enrollment/Change Form Member Health History Form (for each Employee and Dependent)
 Employee Checklist (not needed for dependents) Proof of Employment

Timelines: All necessary enrollment forms, documents and two months' premium must be received before the 20th of the month prior to the effective date to ensure coverage will be in effect for the new employee or dependent on the first of the following month. Please allow up to 3 weeks from receipt date for processing, including member identification cards.

Premiums: Two months' premium for each added member must be included with the required paperwork.

Newborns (Birth, Adoption or Legal Placement): Newborns must be added within 30 days of the birth with required two months' premium payment. Birth certificate must be received by HCGA within 60 days or the newborn will not be covered retroactive to the date of birth. If adoption or legal placement, a copy of documents conveying legal status of newborn must be included.

PLEASE NOTE: Check(s) issued to Healthcare Group of Arizona for a premium payment does not bind coverage. The check(s) will be processed and placed in a credit account pending completion of group's enrollment. If eligible, the amount will be applied toward the premium payment.

COBRA COVERAGE (if currently on COBRA or applying for COBRA)**COBRA ELIGIBILITY:**

- Applies to Employer groups with 20 or more employees
- Employees and their dependents are eligible for COBRA coverage if enrolled with a group of 20 or more employees
- Applicants have 60 days after their group coverage ends to convert to a COBRA policy
- The employer group must continue offering the HCG coverage for eligible employees to enroll in COBRA coverage

I UNDERSTAND THAT:

- My COBRA coverage is subject to state and federal laws; AND
- I am subject to the terms and conditions of the Employer Group Service Agreement; AND
- I am financially responsible for payment of this coverage and that my failure to pay will result in loss of coverage.
Employers are responsible for the Administration of the COBRA coverage including collection of the premiums.

HCG NON-COBRA CONTINUATION COVERAGE (if applying for Non-COBRA Continuation Coverage)**HCG NON-COBRA CONTINUATION ELIGIBILITY:**

- Employer groups with fewer than 20 employees
- The maximum amount of time an individual may be covered under a non-COBRA continuation policy is 3 months.
- Employees and their dependents who were enrolled in HCG coverage under an Employer Group with fewer than 20 full-time employees for at least 6 months who lose their eligibility due to reduction in work hours or termination of employment other than for gross misconduct or due to divorce from or death of the employee are eligible for non-COBRA continuation coverage.
- Applicants must enroll within 31 days of the month following the termination; there can be no gap in coverage.

I UNDERSTAND THAT:

- My non-COBRA continuation coverage is subject to state and federal laws; AND
- I am subject to the terms and conditions of the Employer Group Service Agreement; AND
- I am financially responsible for payment of this coverage to Healthcare Group of Arizona and that my failure to pay to pay will result in loss of coverage.
- Coverage will not be available if the original employer group terminates coverage with Healthcare Group.
- A new group number will be assigned for me.

WAIVER OF HEALTHCARE COVERAGE (necessary if WAIVING health coverage upon initial group enrollment only)**I UNDERSTAND THAT BY SIGNING THIS FORM, I AM WAIVING HEALTHCARE GROUP COVERAGE.**

You may elect to waive participation in the Healthcare Group program if you have other healthcare coverage that is:

- Group health coverage through a spouse, parent, or legal guardian, OR
- Government subsidized healthcare program, OR
- An individual plan

If you waive Healthcare Group coverage because you have other health coverage, you are eligible to enroll in the future providing that you request enrollment within 30 days after the other health coverage ends and will be subject to late enrollee pre-existing conditions.

CONTACT INFORMATION FOR HEALTH PLANS

Mercy Healthcare Group Member Services: 602.798.2800 or 800.780.2300

University Physicians Healthcare Group Member Services: 520.690.6811 (Pima County) 888.708.2930 (Outside of Pima County)

All information contained on this form is considered confidential and may be used strictly for program management and statistical reporting purposes by Healthcare Group of Arizona.