



## Welcome to Healthcare Group of Arizona!

www.hcgaz.com • 602.417.6755 • 800.247.2289 (outside Maricopa County)  
701 E. Jefferson St. • MD 1400 • Phoenix, AZ 85034 • Fax: 602.417.6798

A State-Sponsored Health Plan

### **Thank you for your interest in Healthcare Group of Arizona!**

As a State-sponsored program, Healthcare Group (HCG) is subject to State laws and any changes made by the Legislature to those laws. In order to obtain healthcare coverage through HCG, your business must complete the applicable enrollment materials and must also meet the guidelines set forth by the State Legislature, as well as all proof of business eligibility requirements.

If you are a group of two participating employees or greater, you may enroll in the HCG program. If you are a group of one, however, recent legislation has removed HCG's authority to enroll groups of one. If only one employee of your business is interested in enrolling, we regret to inform you that your business is ineligible at this time.

***All newly-enrolling groups are encouraged to attend an enrollment workshop to ensure your enrollment will be processed timely and that it contains all the required documentation.***

The workshops will not only highlight the benefits of the plan options, but will explain the plan exclusions. An updated workshop schedule can be found on our calendar online at [www.hcgaz.com](http://www.hcgaz.com).

If you are unable to attend an enrollment workshop, please contact HCG to speak with an Enrollment Associate who will be happy to answer any questions and discuss all plan options with you. Please email [newbusiness@hcgaz.com](mailto:newbusiness@hcgaz.com) or call **602.417.6755** or **800.247.2289** (outside of Maricopa County).

For your convenience, the Group Service Agreement, Member Handbook, benefit options, premium rates, and all of the enclosed forms are online at [www.hcgaz.com](http://www.hcgaz.com) under "Documents and Forms".

For additional information regarding the State-sponsored program for small businesses, please e-mail [newbusiness@hcgaz.com](mailto:newbusiness@hcgaz.com) or call 602.417.6755 or 800.247.2289 (outside Maricopa County).

We look forward to serving your healthcare needs!

## Group Service Agreement

The Group Service Agreement is the contract between a qualified business and Healthcare Group of Arizona (HCG) for your healthcare coverage. It contains information on eligibility for the program, participation requirements and covered services. It also discusses the requirements for timely premium payments.

- Action Required:** Read and sign the last page of the Acknowledgement of Receipt and Reading of Group Service Agreements and Benefit Plan Summaries form and submit it along with your application.

## Acknowledgement of Bare Period

This document verifies that your business has met the Bare Period in effect as of the effective date of enrollment.

- Action Required:** Complete the Acknowledgment of Bare Period form and submit it along with your application.

## Premium Rate Charts and Health Plan Selection by County

Refer to the Premium Rate Charts online for premium rates and for health plans available in your county. Rates may vary by county and number of employees. Rates for Dental and Vision coverage are included in this packet. When making your health plan selection, please refer to the following information.

Choose a health plan according to the employee's residence (*some benefit plans are not available in all counties*):

Mercy Healthcare Group (HMO)	University Physicians Healthcare Group (HMO)
Gila Graham Greenlee Maricopa Pima Pinal Santa Cruz Yuma	Cochise Graham Greenlee Maricopa Pima Pinal Santa Cruz

- Action Required:** Have your employees choose a health plan and indicate their selection on the **Group Enrollment/Change Form** and submit along with your application. Existing enrollees will be required to stay with the same health plan during the term of your **Group Service Agreement (GSA)**.

- Action Required:** Review the Premium Rate Charts by county online. Please visit [www.hacgaz.com](http://www.hacgaz.com) and click on "Our Rates".

**Proof of Business**

Review the enclosed Proof of Business Checklist for more information.

- Action Required:** You must provide **current** proof of business activity. Copy the appropriate documents and submit with your application. If necessary, Healthcare Group Administration may request additional documentation from you.

**Group Enrollment Change Form**

- Action Required:** Complete the **Group Enrollment/Change Form** and submit with your application. List all eligible (those who work at least 20 hours per week) employees including those waiving coverage. The **Premium Rate Charts** online will help determine the correct premium for each employee. Calculate the premium for your group on the back side of the **Group Enrollment/Change Form**.

**Please Note:** If your Group Size is 2-5, all employees must enroll or validly waive coverage.

If your Group Size is 6-50, 80% of the eligible employees must participate or validly waive coverage.

**Valid Waiver of Coverage**

Employees who currently have other healthcare coverage through a spouse, parent, legal guardian, or employees who participate in a government-subsidized healthcare program may validly waive participation.

- Action Required:** The employee must complete the Employee/Dependent Enrollment/Change Form and submit proof of other healthcare coverage (copy of current health plan member ID card). If the employee resides out of state, proof of out-of-state residency must be provided.

**Employee/Dependent Enrollment/Change Form**

Eligible employees are those working at least 20 hours per week. Eligible employees are required to complete the **Employee/Dependent Enrollment/Change Form**. Dependents may only be enrolled if the employee is enrolled.

- Action Required:** Obtain completed **Employee/Dependent Enrollment/Change Form** from all eligible employees and submit with the enrollment application.

**Enrollment Effective Date**

Use the following table to determine when your effective date will be. If you have other group coverage that is ending and you do not want a gap in coverage of longer than 63 days, pay close attention to the application date and premium payment requirements. Paperwork must be completed and received by Healthcare Group by the 15th day of the month.

Completed Paperwork Received by HCG	With Two Premiums, Coverage Begins	With One Premiums, Coverage Begins
January 15	February 1	March 1
February 15	March 1	April 1
March 15	April 1	May 1
April 15	May 1	June 1
May 15	June 1	July 1
June 15	July 1	August 1
July 15	August 1	September 1
August 15	September 1	October 1
September 15	October 1	November 1
October 15	November 1	December 1
November 15	December 1	January 1
December 15	January 1	February 1

**Member Health History Form**

Each newly-enrolling employee and dependent is required to complete the **Member Health History Form**.

- Action Required:** Obtain completed **Health History Forms** from all enrolling employees and dependents and submit with the enrollment application.

**Certificate of Creditable Coverage**

Your previous healthcare plan is responsible for providing a Certificate of Creditable Coverage to you. To avoid pre-existing conditions and uninterrupted coverage (if applicable) please know it is your responsibility to submit your Certificate(s) of Creditable Coverage to Healthcare Group immediately upon receipt.

- Action Required:** Call the Customer Service department of your previous insurance carrier to obtain a certificate.

**Premium Payments**

Checks issued to Healthcare Group of Arizona for a premium payment do not bind coverage. The check will be processed and placed in a credit account pending completion of your group's enrollment. If approved, the amount will be used toward your premium payment. If not eligible, a refund check will be issued to the employer, which can take up to 45 days.

**Who Can I Contact for Help?**

**Healthcare Group Administration Customer Service:** 602.417.6755 or 800.247.2289 (outside Maricopa County), E-mail: [hcg@hcgaz.com](mailto:hcg@hcgaz.com)

**Call Center Hours:** Monday through Friday, 8 AM to 5 PM

**Lobby Hours:** Monday through Friday, 8 AM to 5 PM

**Please Return Forms to:**

**Healthcare Group Administration:** 701 E. Jefferson St., MD 1400, Phoenix, AZ 85034 [or] **Fax:** 602.417.6798



# Acknowledgment of Receipt and Reading of Group Service Agreements and Benefit Plan Summaries

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Please read and initial each section below.

**I am aware and understand:**

\_\_\_\_\_ I can locate an electronic version of the Group Service Agreement (GSA) and the *Healthstyles* Benefit Plan Summary for the benefit option(s) chosen by my employees to determine the covered benefits online at **www.hcgaz.com**, on the "Documents and Forms" page.

\_\_\_\_\_ I am **REQUIRED** to and **HAVE** read the GSA and the *Healthstyles* Benefit Plan Summary.

\_\_\_\_\_ I can e-mail Healthcare Group at **hcg@hcgaz.com** or contact HCG Customer Service at 602.417.6755 or 800.247.2289 (outside Maricopa County) to request an electronic version of the GSA and Benefit Plan Summary via e-mail to my personal or business e-mail address.

\_\_\_\_\_ If I do not have access to a computer, I can call Healthcare Group Customer Service at 602.417.6755 or 800.247.2289 (outside Maricopa County) to receive a paper copy of the GSA and Benefit Plan Summary via regular mail.

\_\_\_\_\_ If I have any questions about the covered benefits for the *Healthstyles* benefit option(s), I can contact a Healthcare Group Customer Service Representative at **hcg@hcgaz.com**, 602.417.6755 or 800.247.2289 (outside Maricopa County).

<b>Group Name</b> (please print) _____	<b>Group ID</b> _____
<b>Employer Signature</b> _____	<b>Date</b> _____
<b>Employer Name</b> (please print) _____	

# Healthstyles Benefit Plan Summary

Effective September 1, 2008

	Classic	Active
<b>Benefit Plan Basics</b>		
<b>Health Plan Networks*</b>	Available health plans are listed in your Group Service Agreement	Available health plans are listed in your Group Service Agreement
<b>Deductible Options</b> <i>With the exception of those services listed at right, the deductible must be met each calendar year before a health plan network will begin making payment for covered services.</i>	<ul style="list-style-type: none"> <li>• Available deductible options can be found on the HCG Premium Rate Charts.</li> <li>• Deductibles and benefit limits are calculated on a calendar year basis and may not correspond to a member's anniversary date.</li> <li>• Co-pays do not apply towards meeting the annual deductible.</li> <li>• A Family deductible is equal to 2 times (2X) the Individual deductible, and is accumulated across all family members.</li> <li>• The deductible applies to all covered services except:               <ul style="list-style-type: none"> <li>- Physician Office Visit (Evaluative &amp; Management only)</li> <li>- Preventive Care/Mammography<sup>1</sup></li> <li>- Basic Lab and X-ray</li> <li>- Emergency Medical Services</li> <li>- Urgent Care Clinic Visits</li> <li>- Prescription Drugs</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Available deductible options can be found on the HCG Premium Rate Charts.</li> <li>• Deductibles and benefit limits are calculated on a calendar year basis and may not correspond to a member's anniversary date.</li> <li>• Co-pays do not apply towards meeting the annual deductible.</li> <li>• A Family deductible is equal to 2 times (2X) the Individual deductible, and is accumulated across all family members.</li> <li>• The deductible applies to all covered services except:               <ul style="list-style-type: none"> <li>- Physician Office Visit (Evaluative &amp; Management only)</li> <li>- Preventive Care/Mammography<sup>1</sup></li> <li>- Basic Lab and X-ray</li> <li>- Emergency Medical Services</li> <li>- Urgent Care Clinic Visits</li> <li>- Prescription Drugs</li> </ul> </li> </ul>
<b>Health Savings Account</b>	Not available.	Not available.
<b>Out-of-Network Benefit</b>	<ul style="list-style-type: none"> <li>• Members are Out-of-Network when receiving services from a provider or health care facility not contracted with their health plan.</li> <li>• When a member is Out-of-Network or Out-of-State, ONLY emergency transportation and emergency services are covered.</li> <li>• Members are responsible for 30% coinsurance for any inpatient services resulting from an emergency admission in an Out-of-Network or Out-of-State facility.</li> <li>• Members are responsible for 100% of the cost of non-emergency care received Out-of-Network or Out-of-State.</li> </ul>	<ul style="list-style-type: none"> <li>• Members are Out-of-Network when receiving services from a provider or health care facility not contracted with their health plan.</li> <li>• When a member is Out-of-Network or Out-of-State, ONLY emergency transportation and emergency services are covered.</li> <li>• Members are responsible for 30% coinsurance for any inpatient services resulting from an emergency admission in an Out-of-Network or Out-of-State facility.</li> <li>• Members are responsible for 100% of the cost of non-emergency care received Out-of-Network or Out-of-State.</li> </ul>
<b>Benefit Maximums</b>	First consecutive 12 month benefit maximum: \$100,000 Lifetime benefit maximum: \$2,000,000	First consecutive 12 month benefit maximum: \$100,000 Lifetime benefit maximum: \$2,000,000
<b>Primary and Preventive Care</b>		
<b>Physician's Office Visit *</b>	Primary care: \$25 co-pay each visit. Specialist: \$35 co-pay each visit. (Eval & Mgmt not subject to deductible.)	Primary care: \$25 co-pay each visit. Specialist: \$35 co-pay each visit. (Eval & Mgmt not subject to deductible.)
<b>Preventive and Wellness Care</b>	Member pays \$25 co-pay. <sup>1</sup> (Not subject to deductible.)	Member pays \$25 co-pay. <sup>1</sup> (Not subject to deductible.)
<b>Mammography Screening</b>	No co-pay for covered services. <sup>1</sup> (Not subject to deductible.)	No co-pay for covered services. <sup>1</sup> (Not subject to deductible.)
<b>Urgent Care Clinic</b>	Member pays \$40 co-pay each visit. (Not subject to deductible.)	Member pays \$40 co-pay each visit. (Not subject to deductible.)
<b>Hospitalization</b>		
<b>Emergency Medical Services</b> (co-pay waived if admitted)	In-Network: Member pays \$300 co-pay Out-of-Network: 30% coinsurance (Not subject to deductible.)	In-Network: Member pays 20% coinsurance. Out-of-Network: 30% coinsurance (Not subject to deductible.)
<b>Emergency Medical Transportation**</b>	Member pays \$100 co-pay. (After deductible.)	Member pays 20% coinsurance. (After deductible.)
<b>Inpatient Hospital Services **</b> (each admission)	<b>Mercy:</b> In-Network: \$800 co-pay <b>UPH/Care1st:</b> In-Network: \$500 co-pay (After deductible.)	In-Network: 20% coinsurance. (After deductible.)
<b>Organ Transplants**</b>	Kidney and Cornea only. Subject to Inpatient benefit.	Kidney and Cornea only. Subject to Inpatient benefit.

This is only a summary of the benefits. A more complete description of the covered benefits and exclusions are contained within the GSA and any Endorsements. Benefits, deductible levels and plan options are subject to change. For the most current information, contact HCG or visit [www.hcgaz.com](http://www.hcgaz.com).

<b>Outpatient Care</b>		
<b>Outpatient Surgery**</b>	Member pays 10% coinsurance. (After deductible.)	Member pays 20% coinsurance. (After deductible.)
<b>Outpatient Diagnostic and Treatment**</b>	Lab: \$10 co-pay X-Ray: \$25 co-pay Imaging: 10% coinsurance All other: 10% coinsurance (After deductible except basic Lab and X-ray.)	Lab: 20% coinsurance X-Ray: 20% coinsurance Imaging: 20% coinsurance All other: 20% coinsurance (After deductible except basic Lab and X-ray.)
<b>Rehabilitation Services**</b> (PT, OT, ST, Cardiac, etc)	Member pays 10% coinsurance. Limit: 24 visits per year. (After deductible.)	Member pays 20% coinsurance. Limit: 24 visits per year. (After deductible.)
<b>Reproductive Care</b>		
<b>Group's 1<sup>st</sup> 12 Months All Services</b>	Maximum benefit of \$500 for maternity. Claims paid in order of receipt. (After deductible.)	No Benefit.
<b>13 Months &amp; Beyond</b>	Member pays \$25 co-pay first visit only (After deductible.)	No Benefit.
<b>Prenatal Delivery</b>	Member pays Inpatient Hospital co-pay/ coinsurance. (After deductible.)	No Benefit.
<b>Family Planning</b>	See physician office visit for PCP.	See physician office visit for PCP.
<b>Sterilization</b>	Vasectomy and Tubal Ligation only -Member responsibility determined by site of care.	Vasectomy and Tubal Ligation only -Member responsibility determined by site of care.
<b>Support and Ancillary Care</b>		
<b>Reconstructive Surgery**</b>	Member responsibility determined by site of care	Member responsibility determined by site of care
<b>Oral Surgery**</b>	Member pays \$20 co-pay each visit. (After deductible.)	Member pays 20% coinsurance. (After deductible.)
<b>Dental Trauma**</b>	Member pays \$20 co-pay each visit. (After deductible.)	Member pays 20% coinsurance. (After deductible.)
<b>Dialysis**</b>	No co-pay. Limit: No limit on visits per year. (After deductible.)	Member pays 50% coinsurance. Limit: No limit on visits per year. (After deductible.)
<b>Skilled Nursing**</b>	No co-pay. Limit: 30 days per year. (After deductible.)	Member pays 20% coinsurance. Limit: 15 days per year. (After deductible.)
<b>Home Healthcare**</b>	No co-pay. Limit: 30 visits per year. (After deductible.)	Member pays 40% coinsurance. Limit: 10 visits per year. (After deductible.)
<b>Hospice Care**</b>	No co-pay. Limit: 60 days per year. (After deductible.)	No Benefit.
<b>Infusion/Injection - Home**</b>	No co-pay. Limit: 45 visits per year. (After deductible.)	No Benefit.
<b>Durable Medical Equipment**</b>	Member pays 10% coinsurance. Limit: \$2500 benefit per year paid by plan. (After deductible.)	Member pays 40% coinsurance. Limit: \$1000 benefit per year paid by plan. (After deductible.)
<b>Orthotics and Prosthetics**</b>	Included in DME benefit (above).	Member pays 40% coinsurance. Limit: \$1000 benefit per year paid by plan. (After deductible.)
<b>Routine Dental &amp; Vision</b>	Optional coverage available.	Optional coverage available.
<b>Prescription Drugs</b>		
<b>Prescription Drugs – Formulary Subject to Change</b>	<b>Tier 1: \$10</b> co-pay (most Generics) <b>Tier 2: \$35</b> co-pay (more expensive Generics and most Preferred) <b>Tier 3: \$55</b> co-pay (Non-Preferred) (Not subject to deductible.)	<b>Tier 1: \$10</b> co-pay (most Generics) <b>Tier 2: \$35</b> co-pay (more expensive Generics and most Preferred) <b>Tier 3: \$55</b> co-pay (Non-Preferred) (Not subject to deductible.)

**Notes:**

\* Specialist visits require a PCP referral.

\*\* Requires or may require Prior Authorization.

<sup>1</sup> Benefits have age, gender, diagnosis and frequency limitations. Refer to the GSA and Member Handbook for more information.



# Acknowledgment of Bare Period

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## NOTIFICATION OF BARE PERIOD

If a commercial carrier currently insures your business, you will not be eligible for HCG coverage until your business has gone without insurance for an effective "bare period." If your business is currently uninsured but was covered by a commercial carrier within the bare period in effect at the time of your application to HCG, your business must remain uninsured for the remainder of the "bare period" time before you and your eligible employees can become effective.

The "bare period" applies only to the business itself and not to individual employees. The bare period does not apply to political subdivisions.

### Frequently Asked Questions:

**Q: My business is currently uninsured and has been for over three months, but many of my employees have their own insurance coverage or are covered under their spouse's policy. Does the bare period apply to us?**

A: The bare period applies to the business as follows: If your business has gone uninsured for three months or longer, then you and your eligible employees will be able to enroll in HCG immediately, even if some of your employees have coverage from other sources.

**Q: My business was insured until 2 months ago when our commercial insurance company discontinued the health plan we selected. If we enroll with HCG, are we subject to the bare period?**

A: No. If your business had commercial coverage and the insurance company itself discontinued that coverage, then the bare period DOES NOT apply. Otherwise, the bare period does apply.

## EMPLOYER'S ACKNOWLEDGMENT OF BARE PERIOD COMPLIANCE

The following information is to be completed by the employer. Please use blue or black ink.

Business Name: \_\_\_\_\_ Effective Contract Date Requested: \_\_\_\_\_

Please answer the following questions, sign this form and return to HCG:

1. The employer currently offers group health coverage benefits to its full-time employees.  Yes  No

2. If this employer group is not currently offering health coverage benefits, did the employer group offer health coverage benefits to its employees within the last three months?  Yes  No

If you answered yes to question number 2, please indicate the name of the insurance company by which the company was previously covered and the date that coverage was discontinued.

Previous Health Insurance Company: \_\_\_\_\_ Date Coverage Ended: \_\_\_\_\_  
(A copy of the owner's member ID card must be attached if the owner has been covered by a healthcare plan during the previous three (3) months.)

By signing this agreement, I certify, under penalty of perjury, that the information provided above is true and correct to the best of my knowledge. I also understand that any contract for healthcare coverage based on false or incomplete information may be voided by the Healthcare Group of Arizona Administration (HCGA). I hereby authorize HCGA to contact \_\_\_\_\_ insurance company to verify the dates of coverage and type of coverage previously provided.

Employer Group Signature \_\_\_\_\_ Date \_\_\_\_\_

Please Print Name \_\_\_\_\_ HCG Rep Signature \_\_\_\_\_

Effective September 1, 2010

### EMPLOYERS DENTAL SERVICE (EDS)

Employers Dental Services has been delivering dental care services in Arizona since 1974. This plan includes: No deductibles; No yearly maximum; No waiting period for basic, preventive or major services; Coverage for pre-existing conditions, except procedures in progress; Orthodontic benefits for children and adults; and Emergency benefit 24 hours a day.

Healthcare Group of Arizona offers the following rate tier structure for dental coverage:

<b>DENTAL HMO</b>	
<b>Rate Tier</b>	<b>Monthly Premium</b>
<b>Tier 1:</b> Employee Only	\$12.50
<b>Tier 2:</b> Employee + Spouse	\$24.50
<b>Tier 3:</b> Employee + Family	\$33.00
<b>Tier 4:</b> Employee + Child(ren)	\$31.00

### THE PRINCIPAL PLAN DENTAL PPO

This plan includes: Large dental network, Good out-of-network benefits, and No waiting period.

Healthcare Group of Arizona offers the following rate tier structure for dental PPO coverage:

<b>DENTAL PPO</b>	
<b>Rate Tier</b>	<b>Monthly Premium</b>
<b>Tier 1:</b> Employee Only	\$38.00
<b>Tier 2:</b> Employee + Spouse	\$75.00
<b>Tier 3:</b> Employee + Family	\$115.00
<b>Tier 4:</b> Employee + Child(ren)	\$78.00

### AVESIS ADVANTAGE PLUS VISION CARE PLAN

Avesis Incorporated has been providing vision insurance in Arizona for over 27 years. After applicable co-payments are met (\$10 exam co-payment, \$10 optical materials co-payment) the following benefits are available every 12 months: Vision exam, Lenses (standard single vision, bifocal & trifocal), and Frame (within plan allowance), or Contact Lens (in lieu of spectacle lenses & frame).

Healthcare Group of Arizona offers the following rate tier structure for vision coverage:

<b>VISION</b>	
<b>Rate Tier</b>	<b>Monthly Premium</b>
<b>Tier 1:</b> Employee Only	\$8.00
<b>Tier 2:</b> Employee + Spouse	\$15.00
<b>Tier 3:</b> Employee + Family	\$22.00
<b>Tier 4:</b> Employee + Child(ren)	\$18.00

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**NEW & RENEWING GROUPS: ALL REQUIRED INFORMATION MUST BE RECEIVED BEFORE A DETERMINATION OF ELIGIBILITY CAN BE MADE**

All applicants must submit the following documents:

1a. **Most recent tax return filed** (Individual or Corporate Federal Income Tax Return with all Schedules & Attachments)\*:  2008  2009  2010  2011

1b. **If the current tax year's return is not yet available, you must also submit:**  A valid request for an extension\*\*

2. **Current Arizona Sales Tax Returns showing active sales if applicable**

3. **Please confirm your group's gross revenue has been met:**  I have employees and have met this gross revenue: \$15,000/year or \$3,750/quarter  
 I do not have employees but have met this gross revenue: \$10,000/yr or \$2,500/quarter

4a. **Proof of employee eligibility:**  Tax & Wage statement attached  Employee payroll documenting number of hours worked and paid attached

4b. **Please confirm that your employee's income is 20 hours/week= \$7,020/year or \$1,755/quarter:**  Yes  No

5. **If a license is required for your business, please provide a copy and let us know what type:**

Realtor \_\_\_\_\_  Other \_\_\_\_\_

**SOLE PROPRIETORS with participating employees, please also submit:** 1040 with all Schedules & Attachments

**CORPORATIONS, please also submit most recent "corporate" tax return:**  1120

**S CORPORATIONS, please also submit:** 1120-S and all Schedules & Attachments

**LLCs, please also submit most recent "corporate" tax return** (check one):

1120  1040 with all Schedules & Attachments  1065 with all Schedules & Attachments

**PARTNERSHIPS, please also submit most recent:** 1065 with all Schedules & Attachments

This checklist was developed to ensure your business provides HCG with the appropriate proof of business and group eligibility forms and information.

**Send your proof of business paperwork to:**

**Healthcare Group Administration**  
701 E. Jefferson St.  
MD 1400  
Phoenix, AZ 85034  
(Or Fax to: 602.417.6798)

\*If you are a new business that has not yet filed taxes, please call HCG's new business enrollment department at 602.417.6755, option 3, for information on acceptable proof of business documentation.

\*\*If you have not timely filed your tax return or do not have a valid extension, you are not eligible to enroll.



# Group Enrollment/Change Form

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## A State-Sponsored Health Plan

Business Name \_\_\_\_\_

Group # \_\_\_\_\_

Enrollment:  New Business/Group  Re-enrollment  Existing

Requested Effective Date (date not guaranteed) \_\_\_\_\_

Change (Complete Section A Only):  Street Address Change  Mailing Address Change

Contact Person Change  Business Name Change  Phone/Fax/E-mail Change

County Change  Ownership Change\*  Tax ID Change\*

Other \_\_\_\_\_

\* Proof is needed for verification

### HCG USE ONLY

Eff. Date \_\_\_\_\_ Late Enroll:  Yes  No

SP Event \_\_\_\_\_

W/P \_\_\_\_\_ Renewal \_\_\_\_\_

Rep. \_\_\_\_\_

Today's Date \_\_\_\_\_

### DATE

### SECTION A

Business Name \_\_\_\_\_ DBA Name \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ E-mail Address \_\_\_\_\_

Business Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Business Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Business Owner Name \_\_\_\_\_ Additional Authorized Contact \_\_\_\_\_

County \_\_\_\_\_ Tax ID/SSN \_\_\_\_\_ Date Business Established \_\_\_\_\_ Nature of Business \_\_\_\_\_

### SECTION B

**Proof of Business** (Check the type of documents you are providing to verify your valid business status):

Sales Tax Return  Personal Tax Return with Schedule C and SE or SEZ form  Corporate Tax Return  60 days of Payroll Records  Unemployment Tax and

Wage Report (with employee listing)  Worker's Comp Report (with employee listing)  Other (please specify) \_\_\_\_\_

**Specify waiting period before new employees are eligible for healthcare coverage:**

None  1 month  2 months  3 months  4 months  5 months  6 months

**Legal Status of Business:**  Sole Proprietor  Limited Liability Company (LLC)  Corporation  Partnership  Other (please specify) \_\_\_\_\_

**Do you participate in Workers Compensation:**  No  Yes If yes, enter carrier name \_\_\_\_\_

**Do you have other medical coverage:**  No  Yes If yes, enter carrier name \_\_\_\_\_

**How did you hear about Healthcare Group of Arizona:**  Newspaper  Magazine  Outdoor Advertising  Received a Mailing  Phone Book  Radio

Television  Friend/Relative  Membership in Association  Health Plan Representative  Conference/Presentation  Internet  Broker/Agent

Doctor  AHCCCS  Other (please specify) \_\_\_\_\_

### SECTION C

Employees must work 20 or more hours per week and reside in Arizona to be eligible. Employees who participate in a government subsidized healthcare program or employees who have other health coverage through a spouse, parent or legal guardian can validly waive participation in the Healthcare Group program. Employees who do not wish to participate in Healthcare Group coverage for other reasons are not validly waived.

**Number of employees working 20 or more hours per week** \_\_\_\_\_

**Number of employees who are enrolling in Healthcare Group coverage** \_\_\_\_\_ **Number of employees who are waiving coverage** \_\_\_\_\_

**The minimum number of eligible employees must participate in order for the business to obtain Healthcare Group coverage.**

**If your business size is:**

Two to five employees working 20 or more hours per week

**Your employee participation must be:**

100% of these employees must either enroll or validly waive coverage. Complete an Employee Enrollment/Change Form for each employee who is enrolling or waiving.

Six or more employees working 20 or more hours per week (up to a maximum of 50).

80% of these employees must either enroll or validly waive coverage. Complete an Employee Enrollment/Change Form for each employee who is enrolling or waiving.

Disclaimer: See "New Group Enrollment" section for information regarding effective dates.

**List all employees, including yourself, who are working 20 or more hours per week.**

For each eligible employee waiving coverage, an Employee Enrollment/Change Form must be submitted with a copy of his or her insurance card. Use the Premium Rate Charts to determine the correct Medical Premium for each employee using the employee's Health Plan, Benefit Option, Rate Tier, Age Range, and Gender. Use the Dental and Vision charts to determine the correct premiums for each employee, using the employee's Rate Tier.

**Use the following worksheet to determine the total premium amount for your group. Use additional sheets if necessary.**

<sup>1</sup> **Health Plans:** MHG = Mercy Healthcare Group UPH = University Physicians Network

<sup>2</sup> **Benefit Options:** H520 = Classic *Healthstyles* \$1,000 deductible H530 = Classic *Healthstyles* \$2,000 deductible H540 = Classic *Healthstyles* \$3,000 deductible  
H710 = Active *Healthstyles* \$500 deductible H720 = Active *Healthstyles* \$1,500 deductible

<sup>3</sup> **Medical Rate Tier for Groups of Two Participating Employees:** A = Employee Only B = Employee and Spouse C = Employee and Family D = Employee and Child(ren)  
**Medical Rate Tier for Groups of 3-50 Participating Employees:** 1 = Employee Only 2 = Employee and Spouse 3 = Employee and Family 4 = Employee and Child(ren)

<sup>4</sup> **Rate Tier for Dental and Vision:** 1 = Employee Only 2 = Employee and Spouse 3 = Employee and Family 4 = Employee and Child(ren)

<sup>5</sup> **Dental Plans:** EDS = Employer Dental Services PRIN = Healthcare Group's Principal Plan Dental PPO

Employee Name	Waived	Hire Date mm/dd/yy	Hours/ Week	Health Plan <sup>1</sup>	Benefit Option <sup>2</sup>	Age Range	Gender M/F	Medical Rate Tier <sup>2</sup>	Dental Rate Tier <sup>4</sup>	Dental Plan Option <sup>5</sup>		Vision Rate Tier <sup>3</sup>	Total Premium
								Medical Premium	Dental Premium	EDS	PRN	Vision Premium	
Example Joe Employee		09/15/10	35	MHG	X020	45-49	M	1 \$xxx.xx	4 \$xxx.xx		X	1 \$xxx.xx	\$xxx.xx
1.													
2.													
3.													
4.													
5.													
6.													
7.													
8.													
9.													
10.													
Total Group Premium													

**Please Note:** Employer Groups must have a minimum of two and maximum of fifty eligible employees on the effective date of their first contract. Check(s) issued to HCG for a premium payment does not bind coverage. The checks will be processed and placed in a credit account pending completion of your group's enrollment. If determined to be eligible, the amount will be used toward your premium payment. If not determined to be eligible, a refund check will be issued to the employer.

**New Group Enrollment:**

- The completed required paperwork must be submitted to the Healthcare Group Administration with your premium payment(s).
- If all required paperwork is received and approved by the 15th day of the month and two months of premiums are enclosed, enrollment will begin the first day of the next month.
- If all required paperwork is received and approved by the 15th day of the month and only one month premium is enclosed, enrollment will begin the first day of the second month (in 45 days).

**Changes:** Paperwork will be processed by Healthcare Group Administration upon receipt of all required documentation.

**Termination of Group Coverage:** The Employer Group can only terminate mid-contract year if a qualifying event has occurred. Written notice via the HCGA termination form must be received by Healthcare Group Administration 30 days prior to the termination date and will be effective at 11:59 p.m. on the last day of the month following the 30 day termination notice.

By signing this application, I declare that I have carefully read, understand and agree to all of the terms and conditions of the HCG Group Service Agreement. I certify that the information on this form is true and correct to the best of my knowledge. I understand that any misrepresentation or omission may nullify coverage of employees and dependents.

Business or Group Contact Signature \_\_\_\_\_ Date \_\_\_\_\_



# 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 • Fax: 602.417.6798

## A State-Sponsored Health Plan

**Business Name** \_\_\_\_\_

**Group ID** \_\_\_\_\_ **Member ID H000#** \_\_\_\_\_

**Please make a selection from one of the following sections (enrollment change, waiver or COBRA):**

- 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  
**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 \_\_\_\_\_

**Please select a Healthcare Group Managed Care Option:**

- 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.

Last Name	First Name	MI	Date of Birth	Gender (m/f)	Relationship	Disabled Adult Dependent	Full-Time Student	Primary Care Physician (Managed Care only)	Existing Patient	Medical	Dental <input type="checkbox"/> EDS <sup>1</sup> <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 <sup>1</sup>						<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 <sup>1</sup>						<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 <sup>1</sup>						<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 <sup>1</sup>						<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 <sup>1</sup>						<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

<sup>1</sup> If Subscriber is enrolling an Adult Dependent, please fill out the Adult Dependent Section (Section D) on the next page/on the back of this form.

<sup>2</sup> If You are Choosing the EDS Dental Plan, enter your family Dentist's name \_\_\_\_\_ Dentist code # \_\_\_\_\_

continued on back/2nd page >>

**Please complete for enrolling Adult Dependents ages 19 up to 26**

Adult Dependent's Last Name \_\_\_\_\_ Adult Dependent's First Name \_\_\_\_\_ MI \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_

County \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ E-mail Address \_\_\_\_\_

Adult Dependent's Employer \_\_\_\_\_ Employer's Phone \_\_\_\_\_

**Please read and initial the following:**

\_\_\_\_\_ I understand that Adult Dependent Coverage will end at age 26 without further notice.

\_\_\_\_\_ I verify that my Adult Dependent is not eligible for employer-sponsored coverage and that this enrollment is pursuant to the Patient Protection and Affordable Care Act.

**INSTRUCTIONS:****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.**Adult Dependents (up to 26 years old):** A copy of the birth certificate or a paternity decree providing proof that the Subscriber is the natural or adoptive parent of the Adult Dependent is required.**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.***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.****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 \_\_\_\_\_

A State-Sponsored Health Plan

**COMPLETE ALL SECTIONS OF THIS FORM.**

Each enrolling member must complete a separate Health History Form.

Member ID (if applicable) \_\_\_\_\_

Business/Group Name \_\_\_\_\_

HCG Group # \_\_\_\_\_

Member Last Name \_\_\_\_\_ Member First Name, MI \_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_

**Race or Ethnicity Code** (This information is designed for the purpose of data collection and will not be used for determining eligibility, rating or claim payment.):

- African American  Asian / Pacific Islander  White  American Indian  Hispanic  Other Race or Ethnicity

**HCG USE ONLY**

(Classic Benefit Options Only)

Maternity Cap:  Yes  No

Cap Removal Date \_\_\_\_\_

**SECTION A**

**Health Conditions:** Each member applying must complete a separate Health History Form.

Please mark **Yes** or **No** if you have consulted with a doctor (MD or DO), physician assistant (PA), nurse practitioner (NP) or therapist in an office, clinic, emergency room, urgent care center or hospital via face-to-face, telephone, correspondence, or any electronic means for medical advice or treatment, or have or taken medication for any condition within the last six (6) months. Information provided on this form will not affect your premium rates or eligibility. **However, withholding or falsifying information is grounds for termination of coverage.** Please read Section C on the next page.

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
		101 Allergies; chronic ear, nose or throat problems			114 Blood vessel or circulation disorder; varicose veins; phlebitis			127 Pregnant now? (Due Date):
		102 Cancer? (type and location):			115 Pulmonary embolism or blood clots			128 History of pregnancy complications or miscarriages
		103 Leukemia; CLL			116 Anemia (low blood count)			129 Arthritis; osteoarthritis; rheumatism
		104 HIV/AIDS			117 Hepatitis A, B or C; cirrhosis of liver; jaundice			130 Osteoporosis
		105 Coronary artery disease; cardiovascular disease; heart disease			118 Substance abuse (alcohol or drugs)			131 Rheumatoid arthritis
		106 Stroke or CVA			119 Psychiatric disorder or mental health disorder; depression; ADD, ADHD			132 Lupus; scleroderma
		107 High cholesterol; hyperlipidemia			120 Migraine headache; chronic headaches; cluster headache			133 Trauma or accident to any part of body; broken bone? (which bone and when):
		108 High blood pressure			121 Convulsions or seizures; epilepsy			134 Stomach problems; stomach ulcers; gallbladder stones
		109 Diabetes			122 Multiple Sclerosis			135 Colitis; Crohn's disease
		110 Dialysis; end stage renal disease; chronic renal disease			123 Paralysis; cerebral palsy (CP); polio or muscular dystrophy			136 Eye disorder; cataracts or glaucoma
		111 Kidney disease; kidney stones			124 Asthma			137 Overweight? Height ____ft ____in Weight ____lb
		112 Transplant of organ or tissue? (Type):			125 Chronic lung disease; emphysema; chronic bronchitis; sleep apnea			138 Tobacco use? (Packs per day): Quit? _____ When? _____
		113 Hemophilia			126 TB			139 Other (list)

If you answered **Yes** to any of the items above, please fill in the required information below.

Condition # from above	Describe the condition or illness and treatment you received	When did this start? (Mo/Year)	When did you last consult a health provider for this condition?	Are you still receiving treatment? Yes or No	Name, city and telephone number of healthcare provider that you last saw for this condition

**Withholding or Falsifying Information is Grounds for Termination of Coverage.**

**Complete Both Sides/Pages of This Form.**

**SECTION B** Medications, Equipment and Supplies

Please list all of the medicines you are currently taking or that have been prescribed (if necessary, utilize additional paper):

Medication	Reason	Dosage & Frequency	Date Prescribed	Prescribing Doctor, City & Phone #	In the last 6 months?	
					Yes	No

To assist with continuity of care, please check mark all of the items (equipment or supplies) you are using now:  Wheelchair  Oxygen  Hospital Bed

Name of company that is supplying equipment \_\_\_\_\_

**SECTION C** Pre-existing Conditions and Creditable Coverage

**Pre-existing Conditions:**

- Pre-existing condition is a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, treatment or medication was recommended or received within six months prior to a member's effective date of coverage under an HCG health benefit package.
- The Healthcare Group program limits coverage for certain pre-existing conditions for 12 months from the effective date of coverage; or, in the case of a "Late Enrollee," 18 months from the effective date of coverage.
- Coverage shall not be provided for covered services related to a pre-existing condition during the pre-existing condition waiting period.
- Pre-existing condition does not include pregnancy, or a genetic condition in the absence of a diagnosis of the condition.

**Creditable Coverage and Certificate of Creditable Coverage:**

- Creditable coverage is defined in A.R.S. § 36-2912 and includes the process of allowing a credit of one month given for each month of creditable coverage a person had under any qualified health plan network if, after the period of coverage and before the effective date of coverage with HCG, there was not more than 63 consecutive days in which the person was uninsured.
- When determining if pre-existing condition waiting period limitations apply, prior insurance coverage is considered.
- If you have a pre-existing condition and you have not provided a certificate of creditable coverage to Healthcare Group, all claims related to the pre-existing condition may be denied.
- This applies to any prior insurance your or any family members had within the last 18 months.
- No pre-existing condition exclusion waivers or credits will be provided until proof of prior coverage is submitted and approved.
- If you have had insurance coverage in the past 18 months, attach a copy of the Certificate of Creditable Coverage to your enrollment form.

**SECTION D** Coordination of Benefits

If you answer Yes to any of the following questions, additional information may be requested.

1. Have you ever suffered from an illness or disability as a result of Employment?  No  Yes
2. Have you ever suffered from an illness or disability as a result of Military Service?  No  Yes
3. Are you currently receiving any type of disability insurance benefits?  No  Yes Payor \_\_\_\_\_
4. Are you eligible for treatment at a VA hospital?  No  Yes

**SECTION E** Current/Prior Health Coverage

You may have other healthcare coverage or Healthcare Group coverage. If you currently have, or recently terminated other health insurance, please provide the following information. Also, please provide certificate(s) of creditable coverage.

Type of Coverage:  Group  Individual  Medicaid (AHCCCS)  Medicare\*  Other: \_\_\_\_\_

Health Plan Name \_\_\_\_\_ Health Plan Address \_\_\_\_\_

Health Plan Phone # \_\_\_\_\_ Will Healthcare Group coverage replace this coverage?  No  Yes

Group/Policy # \_\_\_\_\_ Coverage Eff. Date \_\_\_\_\_ Coverage End Date \_\_\_\_\_

\*Medicare Card # (if applicable) \_\_\_\_\_ Eff. Date \_\_\_\_\_  Part A  Part B  Part D  Advantage

**SECTION F** Disclosure Statement and Signature

**DISCLOSURE STATEMENT:** I certify that the information provided on this form is complete and true to the best of my knowledge and is the basis of my enrollment in Healthcare Group. Furthermore, I understand that:

- Any visit or consultation in any form with a medical provider at which testing, diagnosis, treatment, or recommendation for treatment for any condition or disease is made between the date on this form and the effective date of coverage must be reported in writing to HCG. If the supplemented information is not reported to HCG, the Member's coverage may be rescinded and the Member will owe the costs of any services paid;
- Any misrepresentation or omission, whether intentional or unintentional, regarding the presence of a pre-existing condition will result in cancellation of my medical coverage;
- I will be responsible for any costs incurred for non-covered services and services that exceed benefit limit or dollar amount listed in my benefit plan while under the plan.

I further understand that any costs associated with providing such information or records will be at my expense and not the expense of Healthcare Group or my Health Plan.

Signature \_\_\_\_\_ Date \_\_\_\_\_

If a Minor, Signature of Parent/Guardian Completing Form \_\_\_\_\_

Relationship \_\_\_\_\_ Date \_\_\_\_\_

Group Name \_\_\_\_\_ Group ID (if applicable) \_\_\_\_\_

**THE FOLLOWING INFORMATION IS TO BE COMPLETED BY THE ENROLLEE. Please read and initial with blue or black ink.**

**I understand/acknowledge:**

\_\_\_\_\_ It is my responsibility to read the Benefit Plan Summary and either the Group Service Agreement or Member Handbook.

\_\_\_\_\_ I have received and read the Benefit Plan Summary for the benefit plan option in which I have chosen to enroll. I understand coverage varies by benefit plan option as summarized within the Benefit Plan Summary and detailed in the Group Service Agreement and Member Handbook.

\_\_\_\_\_ The Benefit Plan Summary lists the co-payments, coinsurance and deductible levels that I am responsible to pay.

**LIMITATIONS – I am aware and understand:**

\_\_\_\_\_ It is my responsibility to read the section titled “Exclusion and Limitations” of the Group Service Agreement. Benefit Exclusions and Limitations are fully described in my online Member Handbook.

\_\_\_\_\_ Pre-existing Conditions: A twelve- (12) or eighteen- (18) month waiting period will apply for pre-existing conditions if I do not provide a Certificate of Creditable Coverage documenting sufficient prior coverage to eliminate the pre-existing condition waiting period. It is my responsibility to supply all letters of creditable coverage from previous health insurers to HCG in order to waive any pre-existing restrictions. Failure to do so may result in my claims being denied.

\_\_\_\_\_ Only medications listed on my health plan’s formulary (prescription drug list) are covered. The formulary drugs are subject to a co-payment or coinsurance and may be subject to step therapy requirements, prior authorization, and annual limits. Most injectable medications are not covered on Healthstyles benefit plans. I understand that no exceptions will be made to the formulary.

\_\_\_\_\_ Healthstyles benefit plans do NOT cover mental health, substance abuse or chiropractic services. Medications used to treat mental health conditions (such as depression, anxiety and ADD) are covered only if listed on my health plan’s formulary.

\_\_\_\_\_ Maternity care is not a covered benefit on the *Active Healthstyles* benefit plan option.

\_\_\_\_\_ If my provider refers me to, or uses the services of, a non-contracted provider or facility for non-emergent services, I am totally responsible for the cost of that care. These non-contracted non-emergent services could include reference labs, pathology labs, radiology centers, DME vendors, and suppliers. I understand that it is my responsibility to ask if the services are with a contracted provider and request that the services be provided by a contracted provider, or I may be responsible for the cost of the services even if they are a covered service under my Benefit plan option.

\_\_\_\_\_ If I personally decide to use the service of a non-contracted provider or hospital for any non-emergent services without a referral, I am totally responsible for the cost of that care. This includes, but is not limited to, provider, hospital, reference labs, pathology labs, radiology centers, DME vendors, and suppliers.

\_\_\_\_\_ All members are subject to a first-year, twelve (12) months of continuous coverage dollar cap of \$100,000 on medical benefits.

Group Name \_\_\_\_\_ Group ID (if applicable) \_\_\_\_\_

**DEDUCTIBLES – I am aware and understand:**

\_\_\_\_\_ All members are subject to an annual deductible and are responsible to read the section titled “Member Co-payments, Coinsurance and Deductibles” in the Group Service Agreement.

\_\_\_\_\_ All members are responsible to pay all co-payments, coinsurance and deductibles as listed on the Member’s benefit plan option Benefit Plan Summary. Services subject to the deductible are listed on the Benefit Plan Summary.

\_\_\_\_\_ Every January 1st the deductibles are set to zero and the Member must pay the full amount of the deductible before HCG pays for any services subject to the deductible. There is no carryover of accumulated deductible to the following calendar year regardless of the renewal date.

\_\_\_\_\_ Co-payments and coinsurance are my responsibility to pay and do not apply toward meeting my annual deductible.

\_\_\_\_\_ Co-payments and coinsurance are the member’s responsibility to access services, in addition to the deductible.

\_\_\_\_\_ The deductible for a family plan equals two (2) times the individual deductible regardless of family size.

*This checklist includes a partial list of the limitations and exclusions. A complete list of limitations and exclusions is provided in the correlating Group Service Agreement and/or Member Handbook. Please retain a copy for your records.*

**Business/Group Name** (please print) \_\_\_\_\_

**Employee Name** (please print) \_\_\_\_\_

**Employee Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



A State-Sponsored Health Plan

- New Request
Change Request
Terminate Authorization

Business Name \_\_\_\_\_

Group ID \_\_\_\_\_

I/We hereby authorize Healthcare Group of Arizona (HCG) to initiate monthly deductions from my/our checking or savings account indicated below, for amounts necessary to pay my/our HCG group healthcare coverage premium from the financial organization indicated. These deductions will be made on the due date of the premium.

Name of Bank, S&L or Credit Union: \_\_\_\_\_

Account Number: \_\_\_\_\_ Routing Number: \_\_\_\_\_

Type of account: [ ] Checking (enclose an original or copy of a voided check) [ ] Savings (enclose deposit slip)

I/We understand this authority is to remain in full force and effect until HCG has received written notification from me (or either of us) of its termination. Please allow at least 15 business days prior to your draft date to process payment. I/we approve an increase or decrease in automatic deductions to my medical group plan. Furthermore, I/we agree to maintain an adequate balance in my/our checking/savings account to cover my/our group medical premiums. Failure to do so will be considered non-payment of premium and coverage will be terminated.

All signers on the bank account indicated above are required to sign this form.

Form with fields for Name (please print), Signature, Date, and Daytime Phone(s) for two signers.

You will be notified on your billing statement that your premium will be processed by automatic debit. The statement will indicate: "AUTOMATIC DEBIT NOTIFICATION". Continue to send checks for your premium payment until you receive your first automatic debit notification.

PLEASE BE SURE TO INCLUDE AN ORIGINAL OR A COPY OF A VOIDED CHECK OR DEPOSIT SLIP FROM YOUR ACCOUNT, OR THERE COULD BE A DELAY IN PROCESSING. (Copies of these items will be accepted)

Mail:
701 E. Jefferson St.
MD 1400
Phoenix, AZ 85034

Fax:
602.417.6798

Questions:
602.417.6755 • 800.247.2289 (outside Maricopa County)

**FAQs Regarding Automatic Debits****How does automatic debit work?**

- With automatic debit, your premium payments will automatically be deducted from your checking or savings account at no extra cost to you.

**How do I sign up?**

- Complete the Authorization Agreement for Automatic Debit form on the reverse of this sheet. Send it to Healthcare Group of Arizona (HCG) along with one of the following:
  1. Include an original or copy of a voided check if payment is to be deducted from your checking account.
  2. Include a savings deposit slip if payment is to be deducted from your savings account.
- Faxed copies of the Authorization Agreement for Automatic Debit form, a check or deposit slip will be accepted.
- Only one automatic debit will be authorized per employer group (and must include premium for all participating employees).

**How will I know when the automatic debit will begin?**

- It will take approximately 45 days for your first debit to be processed. You will receive an Automatic Debit Notification on your billing statement from HCG that will include the date of your first automatic debit.
- Be sure to continue sending your premium payment by check until you receive the HCG automatic debit notification.

**How much will be deducted from my account?**

- The amount deducted from your account will be the same amount reflected on your Automatic Debit Notification from HCG. Any adjustments (adding new employees/dependents, terminating employees, etc.) that have been made to your account after the billing statement has been mailed may change the upcoming automatic debit amount, however won't be reflected until the next month's billing notification.
- Any past due amount must be paid by another form of payment before the upcoming automatic debit will be processed.
- Past due amounts are outstanding balances for plan adjustments (listed above) which create an amount due for premiums which may have already been paid for the current service month.

**If I want to add an employee or dependent, can you deduct their two-month premium from my automatic debit account?**

- No as these are considered two separate transactions
- We only draft 1 month's premium. Any requested changes to benefits will **ONLY** be effective **AFTER** full difference in premium is received.

**What happens if there are insufficient funds in my account when the automatic debit takes place?**

- If HCG receives notification that there are insufficient funds in your account to cover the automatic debit of your premium payment, you will immediately be taken out of the HCG automatic debit system. You will receive a notification letter from HCG stating that continuance of your healthcare coverage requires that you submit a cashier's check or money order for the premium payment amount within a specified time frame.
- If you are interested in re-applying for the automatic debit payment option, a 60-day waiting period is required and approval will be at the discretion of HCG.

**What should I do if I want to change my bank account?**

- Resubmit the automatic debit notification paperwork listed above with the updated bank account information.
- Allow 15 days prior to the premium date for the change to be processed for a different account within the existing banking institution. Allow 30 days for processing for account changes to a different banking institution.

**How do I cancel my automatic debit?**

- Complete the Authorization Agreement for Automatic Debit form and select "Terminate Authorization" or send a letter with your business name and HCG Group ID requesting cancellation of your automatic debit and the date for cancellation.
- Allow at least 15 days prior to the due date for the cancellation to be processed.



# Acknowledgement of Receipt Healthcare Group of Arizona Dental Plans

www.hcgaz.com • 602.417.6755 • 800.247.2289 (outside Maricopa County)  
701 E. Jefferson St. • MD 1400 • Phoenix, AZ 85034 • Fax: 602.417.6798

A State-Sponsored Health Plan

### TERMS OF AGREEMENT

Dental coverage through the EDS Dental HMO Plan and the Principal Plan Dental PPO shall take effect on the group's contract effective date for medical benefits and shall remain in effect for a term of one year. Dental benefits cannot be terminated independent of the group's medical benefits. Dental coverage is renewable each year provided Healthcare Group Administration (HCGA) has verified that the group remains eligible for the Healthcare Group (HCG) program, and the group renews medical coverage, and ask any questions that I may have regarding coverage/benefits.

### Please read and initial each section below.

\_\_\_\_\_ I understand that HCG's dental HMO plan is provided by Employers Dental Services and HCG's dental PPO plan is provided by Principal Life.

\_\_\_\_\_ I understand that dental benefits are subject to the limitations and exclusions set forth in EDS' Enrollment and Coverage Booklet 700R and Healthcare Group's Principal Plan Dental PPO Benefit Summary.

\_\_\_\_\_ I understand that dental benefits are subject to the governing conditions and provisions of the HCG program as set forth in the Group Service Agreement.

\_\_\_\_\_ I understand that grievances and appeals related to dental benefits are subject to the HCG appeal process as set forth in the HCG Group Service Agreement and Member Handbook.

\_\_\_\_\_ I understand that dental benefits run on the same contract cycle as the group's medical benefits and cannot be terminated independently.

### Acceptance

By signing this acknowledgement, the undersigned parties agree to all terms and conditions contained in the coverage documents mentioned above, including any and all attachments.

<b>Group Name</b> (please print) _____	<b>Group ID</b> _____
<b>Group Address, City, State, Zip</b> _____	
<b>Employer Name</b> (please print) _____	
<b>Employer Signature</b> _____	<b>Date</b> _____

<b>Authorizing HCG Employee</b> (please print) _____	
<b>HCG Authorized Signature</b> _____	<b>Date</b> _____



# Acknowledgement of Receipt Avesis Advantage Plus Vision Benefits

www.hcgaz.com • 602.417.6755 • 800.247.2289 (outside Maricopa County)  
701 E. Jefferson St. • MD 1400 • Phoenix, AZ 85034 • Fax: 602.417.6798

A State-Sponsored Health Plan

### TERMS OF AGREEMENT

Vision coverage through Avesis shall take effect on the group’s contract effective date for medical benefits and shall remain in effect for a term of one year. Vision coverage cannot be terminated independent of the group’s medical benefits. Vision coverage is renewable each year provided Healthcare Group Administration (HCGA) has verified that the group remains eligible for the Healthcare Group (HCG) program, and the group renews medical coverage.

### Please read and initial each section below.

\_\_\_\_\_ I understand that vision coverage offered through HCG is provided by Avesis.

\_\_\_\_\_ I understand that vision benefits are subject to the limitations and exclusions set forth in the document titled “Healthcare Group Advantage Plus Vision Plan Through Avesis.”

\_\_\_\_\_ I understand that vision benefits are subject to the governing conditions and provisions of the HCG program as set forth in the HCG Group Service Agreement.

\_\_\_\_\_ I understand that vision benefits run on the same contract cycle as the group’s medical benefits and cannot be terminated independently.

### Acceptance

By signing this acknowledgement, the undersigned parties agree to all terms and conditions contained in the document titled “Healthcare Group Advantage Plus Vision Plan Through Avesis,” including any and all attachments.

<b>Group Name</b> (please print) _____	<b>Group ID</b> _____
<b>Group Address, City, State, Zip</b> _____	
<b>Employer Name</b> (please print) _____	
<b>Employer Signature</b> _____	<b>Date</b> _____

<b>Authorizing HCG Employee</b> (please print) _____
<b>HCG Authorized Signature</b> _____
<b>Date</b> _____



# Employer New Group Enrollment Memorandum of Understanding

www.hcgaz.com • 602.417.6755 • 800.247.2289 (outside Maricopa County)  
701 E. Jefferson St. • MD 1400 • Phoenix, AZ 85034 • Fax: 602.417.6798

A State-Sponsored Health Plan

**Please read and initial each section below.**

- \_\_\_\_\_ I understand that upon enrollment and on the coverage effective date the signed Group Service Agreement is the contract which governs our group coverage.
- \_\_\_\_\_ I understand that submitting a completed enrollment packet and required premiums is NOT a guarantee of coverage. I will receive a written confirmation of coverage.
- \_\_\_\_\_ If my Employer Group is determined to be in-eligible for Healthcare Group of Arizona (HCG) coverage prior to the initial enrollment date the premiums paid will be refunded and may take up to 4 weeks to process.
- \_\_\_\_\_ I understand that I should not terminate any other medical coverage prior to the written confirmation that my Employer Group has been enrolled with HCG.
- \_\_\_\_\_ I understand that my business must meet the eligibility requirements of annual gross income at least \$15000 for the group with a minimum of 2 employees upon enrollment, no more than 50 employees working no fewer than 20 hours a week earning at least the current minimum wage.
- \_\_\_\_\_ I understand that my Employer Group must maintain and pay premiums for a minimum of 2 employees for the first 6 months of enrollment. Any request to terminate an employee within the initial 6 months of enrollment will not be honored and the group will continue to be billed for a minimum of 2 enrolled employees. Non-payment of the total amount due will result in termination of group coverage.
- \_\_\_\_\_ I understand that premiums are due the 1st of the month prior to the coverage month. If premiums are not paid prior to the 1st day of the coverage month, our group coverage may be terminated and our business may be unable to re-apply for at least 90 days.
- \_\_\_\_\_ I understand that it is my responsibility and the responsibility of any enrolling employees to review the Network Listing for Providers and make any Formulary inquiries that may be necessary prior to choosing a network. It is further understood that changes to the Network Providers and Formulary may occur anytime during my enrollment.
- \_\_\_\_\_ I understand that the plan deductible is twice the individual deductible for a family enrollment.

<b>Group Name</b> (please print) _____	<b>Group ID</b> _____
<b>Employer Name</b> (please print) _____	
<b>Employer Signature</b> _____	<b>Date</b> _____