Point32Health Dental | Point32Health Vision

This enrollment form applies to Point32Health Dental and Vision coverage only.

Point32Health Dental and Point32Health Vision insurance products are underwritten by HPHC Insurance Company, Inc.

REASON FOR SUBMISSION (PLEASE CHECK ONE)
☐NEW ENROLLMENT/CONTRACT
☐CHANGE TO CONTRACT
☐TERMINATE CONTRACT

QUALIFYING EVENT DATE:________________
☐ OPEN ENROLLMENT ☐NEW HIRE ☐COBRA ☐LOSS OF INSURANCE ☐COURT ORDER ☐BIRTH/ADOPTION
☐ P/T TO F/T ☐MARRIAGE/DIVORCE ☐ DEATH
☐ VOLUNTARY CANCELLATION

REASON FOR CHANGE(S) (CHECK ALL THAT APPLY)
☐CHANGE COVERAGE TYPE ☐ADD DEPENDENT LISTED ☐TERMINATE DEPENDENT LISTED ☐TRANSFER/RE-ENROLL TO COBRA
☐OTHER:____

EMPLOYER/GROUP INFO (TO BE COMPLETED BY EMPLOYER)

EMPLOYER/GROUP NAME	*DENTAL GROUP #DIVISION*	*VISION GROUP #DIVISION*	*DATE OF HIRE*	*EFFECTIVEDATE OF DENTAL COVERAGE*	*EFFECTIVE DATE OF VISION COVERAGE*

SUBSCRIBER INFORMATION

ID	*LINE OF COVERAGE:* ☐DENTAL ☐VISION	*Dental Plan Name*	*Vision Plan Name*

SUBSCRIBER FIRST NAME	*MI*	*LAST NAME*	*DOB*	*GENDER* ☐M ☐F

SSN	*HOME PHONE*	*WORK PHONE*	*CELL PHONE*	*EMAIL*

STREET ADDRESS (NO PO BOX)	*APT #*	*CITY*	*STATE*	*ZIP*

PRIMARY LANGUAGE (OPTIONAL)

SPOUSE INFORMATION

SPOUSE FIRST NAME	*MI*	*LAST NAME*	*DOB*	*GENDER* ☐M ☐F

SSN	*MAILING ADDRESS (IF DIFFERENT)*	*RELATION CODE*

ENROLLING IN THE FOLLOWING LINES OF COVERAGE
☐DENTAL ☐VISION

DEPENDENT INFORMATION

DEPENDENT FIRST NAME	*MI*	*LAST NAME*	*DOB*	*GENDER* ☐M ☐F	*RELATION CODE*

MAILING ADDRESS (IF DIFFERENT)	*SSN*

ENROLLING IN THE FOLLOWING LINES OF COVERAGE
☐DENTAL ☐VISION

DEPENDENT INFORMATION

DEPENDENT FIRST NAME	*MI*	*LAST NAME*	*DOB*	*GENDER* ☐M ☐F	*RELATION CODE*

MAILING ADDRESS (IF DIFFERENT)	*SSN*

ENROLLING IN THE FOLLOWING LINES OF COVERAGE
☐DENTAL ☐VISION

DEPENDENT INFORMATION

DEPENDENT FIRST NAME	*MI*	*LAST NAME*	*DOB*	*GENDER* ☐M ☐F	*RELATION CODE*

MAILING ADDRESS (IF DIFFERENT)	*SSN*

ENROLLING IN THE FOLLOWING LINES OF COVERAGE
☐DENTAL ☐VISION

☐PLEASE CHECK IF USING ADDITIONAL MEMBERSHIP APPLICATIONS FOR DEPENDENT CHILDREN. BE SURE TO COMPLETE EMPLOYER AND SUBSCRIBER SECTIONS ON ADDITIONAL FORMS

OTHER INSURANCE – IF YOU HAVE NOT COMPLETED THIS SECTION, YOU MAY RECEIVE A FOLLOW-UP QUESTIONNAIRE AND CLAIMS MAY BE DELAYED.

ARE YOU OR ANYONE LISTED ABOVE COVERED BY ANOTHER DENTAL AND/OR VISION INSURANCE POLICY AT THE SAME TIME YOUR HPHC POLICY IS IN EFFECT? ☐YES. PLEASE COMPLETE ☐NO

NAME OF DENTAL PLAN	*DENTAL PLAN ID NUMBER*	*EFFECTIVE DATE*	*NAMES OF SUBSCRIBER*
NAME OF VISION PLAN	*VISION PLAN ID NUMBER*	*EFFECTIVE DATE*	*NAMES OF SUBSCRIBER*

MEMBERSHIP WILL BECOME EFFECTIVE UPON ACCEPTANCE BY POINT32HEALTH. BENEFITS UNDER THE PLAN WILL BE EXPLAINED IN YOUR EVIDENCE OF COVERAGE (EOC). I UNDERSTAND THAT POINT32HEALTH MAY OBTAIN PERSONAL AND MEDICAL INFORMATION TO ADMINSTER THE PLAN. FOR AN EXPLANATION OF HOW WE MAY USE OR DISCLOSE PROTECTED HEALTH INFORMATION, PLEASE READ YOUR NOTICE OF PRIVACY PRACTICES.
IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, IMCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPLANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR DENIAL OF INSURANCE BENEFITS.

________________________ *EMPLOYEE SIGNATURE* ____________ *DATE* ________________________ *EMPLOYER SIGNATURE* ____________ *DATE*

Thank you for choosing Point32Health Dental and Vision.

Please read the following instructions prior to completing this enrollment/change form. This form may be used for all enrollment transactions (Adding coverage, changing coverage, terminating coverage). In order to add, change or terminate coverage you must (1) experience a qualifying event, (2) complete this enrollment, and (3) provide the completed form to your employer within the allowed timeframe or approved retroactive period.

Qualifying Events:

New Enrollment	**Contract change**	**Termination**
Open Enrollment	Open Enrollment	Open Enrollment
New hire date	Marriage/Divorce	Voluntary Cancellation
Probationary Period (if applicable)	Birth/Adoption/Court Order	Left Employment
Loss of Insurance	Loss of Insurance	No Longer Eligible (e.g. deceased, LOA, laid off, COBRA nonpayment)
Employment Status Change	Loss of Employer Premium contributions	

Employer Section: Your Employer must fill out this section as well as the Reason for Submission in full for any transactions that this form is used for.

Member Section: Please complete all of the employee sections of this membership application in full. Failure to do so could delay enrollment. You will receive your ID card(s) and member benefit documents after your enrollment has been fully processed. If you are adding or removing a dependent(s), just include the details about the dependent(s) that you are adding or removing off the plan.

- **Line of Coverage/Plan Name:** Please be sure to fill in the correct line of coverage for which you will be enrolling. Your options are dental, vision, or both. If enrolling in both, please make sure both are accurately checked off. If your employer offers multiple Point32Health Dental and Vision Plans, please indicate the Plan name as listed on the enrollment materials to help clearly differentiate the plan you are choosing.
- **Personal Information:** In addition to yourself, please include the personal information for every dependent that will be enrolled on the Plan. ***IMPORTANT: Social security numbers (or personal tax identification number) for each member on the plan are needed to ensure that federal regulatory reporting requirements are met. Social security numbers are not displayed on the member's ID card.***
- **Relation Code:** Please use one of the following codes to designate the dependent's relationship to the Employee:
  - 02 Spouse/Civil Union
  - 03 Child up to age 26
  - 06 Disabled (verification required)
  - 07 Ex-spouse
  - DP Domestic Partner
  - SE Spousal Equivalent

When this application is complete: Please sign the enrollment form and provide it to your employer. Your employer will need to sign this form and will forward this application to Point32Health Dental and Vision for processing. If you need additional assistance completing this form, please call a member services coordinator at 1-888-333-4742.