Employee Enrollment / Change Application

P.O Box 297 Minneapolis, MN 55440-0297	Fax: 952-883-5950	Group Number Effective Date

□**New Applicant** □**Change of Coverage (explain change)**

□**Name/Address Change (note changes in appropriate sections below)** **Check Qualifying Event:** □New Hire □Open Enrollment

□Employment Termination □Loss of Coverage □Birth □Adoption □Marriage □COBRA coverage exhausted □Divorce □Death

□Cancel Coverage (reason) _____

□Drop Dependent(s)(list names) _____

Benefit Plan Option Selected, if applicable:

I. Employer Information

Employer Location / Department

Street Address City State Zip

Avg Hours Worked per Week: □Full-Time □Part-Time Date of Hire ____/____/____ □Retiree □COBRA

II. Primary Applicant (Employee) Information

Last Name	First Name	MI	Disabled? □No □Yes If yes, effective date: ____/____/____	Social Security Number

Mailing Address (street and PO Box if applicable) City State Zip Code

Date of Birth	□Male □Female	Marital Status: □Married □Single □Domestic Partner □Divorced □Widowed
_____/_____/_____		

Home Phone Number	□Cell Phone OR □Alternate Phone	E-mail Address
( )_____-_____	( )_____-_____	

III. Personal Information for Additional Applicants

Complete the following information for each person in your family who is applying for coverage or being added to existing coverage, including your spouse and any eligible dependents (to age 26 unless disabled). Use additional forms if necessary.

Relation-ship	Full Name (First, MI, Last)	Birthdate Mo/Day/Yr	Social Security Number	Gender	Disabled? Effective Date
		___/___/___		□Male □Female	□No □Yes ___/___/___
		___/___/___		□Male □Female	□No □Yes ___/___/___
		___/___/___		□Male □Female	□No □Yes ___/___/___
		___/___/___		□Male □Female	□No □Yes ___/___/___
		___/___/___		□Male □Female	□No □Yes ___/___/___
		___/___/___		□Male □Female	□No □Yes ___/___/___

IV. Waiver of Coverage - you must complete this section if you or your dependents DO NOT want coverage.

□ I am declining coverage due to existence of other coverage: □Group Plan □Individual Plan

□Continuation /COBRA □Medicare □VA Eligible □Medicaid □Tri-Care □Children's Health Insurance Program

□I (and/or family members) choose to be without coverage □Other, explain:

I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a life change event, at the next open enrollment period or as a special enrollee, if applicable.

Signature if Waiving Date Signed / /

V. Other Medical Coverage - If any person(s) on this application will have other active medical insurance, along with this coverage, you must complete this section. (Including Medicare)

Contract Holder	Other Carrier Name	Carrier Phone Number	Policy Number	Effective Date	Contract Type: Single, 2-Person, Family, etc.
		( ) _____-_____			
		( ) _____-_____			

VI. Tobacco Use

Has any person on this application routinely used tobacco products (average 4 times per week) within the past 6 months? □No □Yes If yes, please list names:

Note any persons listed above who plan to enroll in and complete a tobacco cessation program in the next sixty (60) days.

VII. Race (Optional - check all that apply.)

If Hispanic/Latino □Mexican □Mexican American □Chicano/a □Puerto Rican □Cuban □Other

□White □American Indian or Alaska Native □Filipino □ Vietnamese □Guamanian or Chamorro □Samoan

□Black or African American □Asian Indian □Japanese □Other Asian □Other Pacific Islander □Chinese

VIII. Application Agreement and Certification

I certify that I am legally authorized to apply for coverage for myself and on behalf of all other persons named in this application. I have consulted with each other person named in this enrollment application to confirm that information about them is full, true, and correct. I confirm that all persons applying for health insurance on this application are U.S. citizens, U.S. nationals, or lawfully present in the U.S. (legal aliens). I hereby apply for coverage on the basis of the statements and answers to the questions herein. I represent all answers to be true and complete to the best of my knowledge, and I understand that providing false information or omission of relevant information in this application may result in the denial of claims or rescission of coverage. I may withdraw this application at any time during processing with written notification. I understand that my application for new or additional coverage will not be effective until CoOportunity Health has received appropriate premium from my Employer.

1. I authorize CoOportunity Health to obtain from health plans, providers of service and hospitals, brokers, the medical and mental and chemical health records relating to me and all other applicants that are necessary for: claims processing, including claims CoOportunity Health makes for reimbursement or subrogation; quality of care assessment and improvement; accreditation, credentialing, case management, care coordination and utilization management, disease management, the evaluation of potential or actual claims against CoOportunity Health auditing and legal services, and other health care operations. If a provider or health plan does not accept a copy of this document as authorization to release my information to CoOportunity Health, then I agree that I will sign a separate authorization. This authorization is valid as long as I am continually insured with CoOportunity Health or until revoked. A reproduction of this authorization shall be as valid as the original. CoOportunity Health may access and use information without further authorization if permitted or required by another law.

2. I authorize CoOportunity Health to release information related to my CoOportunity Health coverage (including information from my medical records) to the primary applicant. This authorization is intended to cover the release of information as described above for myself as well as any dependents on whose behalf I have applied for CoOportunity Health employer group coverage.
3. I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
4. I understand that my information on this enrollment application will only be used to determine eligibility for health insurance and will be kept private as required by law. I know that I must notify my employer if anything changes (and is different than) what I wrote on this application. My employer can visit www.cooportunityhealth.com to report any changes.
5. If I answered "No" to the Tobacco Declaration for any person listed on this application, that person is eligible for a special tobacco non-user rate. If this status changes, I must notify CoOportunity Health immediately.

IX. Agreement and Certification Acceptance

I certify that I have read and understand the Agreement and Certification above, and that I agree to the terms stated therein.

Applicant Signature	Date Signed / /

Please submit the completed enrollment application to your employer or as instructed by your employer. Keep a copy of the completed application as it will become a part of your CoOportunity Health record.