Healthfirst Insurance Company, Inc.

Small Group Employee Enrollment Form

Mailing Address:
Healthfirst Insurance Company, Inc., Commercial Sales, 100 Church Street, New York, NY 10007

Please print neatly using black or blue ink, complete the enrollment form **in full**, and **sign** the last page. Incomplete or unsigned forms will not be processed.

Section 1 | Company Information

To be completed by Plan Administrator:

Company Name	Billing Group (If Applicable)	Group Number
Effective Date / /	Title	Date of Hire (MM/DD/YYYY) / /
Employer Signature	Date / /	Class: ☐ I ☐ II

Section 2 | Transaction Type

(check all that apply)

☐ Open Enrollment ☐ New Hire ☐ Rehire

Qualifying Life Event:

☐ COBRA ☐ State Continuation ☐ Young Adult Event Date: ___ /___ /____

Section 3 | Coverage Selection

Please refer to your employer's health insurance plan option(s) and write your choice here:

____

Please select from the plan(s) that your employer is offering. Check with your employer or plan administrator if there are any questions.

Section 4 | Employee Information

Name: ____

Address: ____

City: ______________________ State: __________ Zip: __________

Section 5 | Employee/Dependent(s) Information

	Employee	Spouse/Domestic Partner	Dependent 1	Dependent 2
Social Security Number (or Tax Identification Number, if applicable)	_____-____-_____	_____-____-_____	_____-____-_____	_____-____-_____
Last Name				
First Name, Middle Initial				
Phone Number				
Email Address				
Date of Birth (MM/DD/YYYY)	/ /	/ /	/ /	/ /
Gender	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Primary Care Physician (PCP) Name				
PCP ID Number (if available)*				
Currently covered under another insurance?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If Yes, select type:	☐ Medical ☐ Dental	☐ Medical ☐ Dental	☐ Medical ☐ Dental	☐ Medical ☐ Dental
Company Name				
Coverage Beginning/End Dates	___/___/____ – ___/___/____	___/___/____ – ___/___/____	___/___/____ – ___/___/____	___/___/____ – ___/___/____
Policy Number				

*If you do not select a PCP, one will be auto-assigned to you.

Section 5 | Employee/Dependent(s) Information (continued)

	Dependent 3	Dependent 4	Dependent 5	Dependent 6
Social Security Number (or Tax Identification Number, if applicable)	_____-____-_____	_____-____-_____	_____-____-_____	_____-____-_____
Last Name				
First Name, Middle Initial				
Phone Number				
Email Address				
Date of Birth (MM/DD/YYYY)	/ /	/ /	/ /	/ /
Gender	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Primary Care Physician (PCP) Name				
PCP ID Number (if available)*				
Currently covered under another insurance?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If Yes, select type:	☐ Medical ☐ Dental	☐ Medical ☐ Dental	☐ Medical ☐ Dental	☐ Medical ☐ Dental
Company Name				
Coverage Beginning/End Dates	___/___/____ – ___/___/____	___/___/____ – ___/___/____	___/___/____ – ___/___/____	___/___/____ – ___/___/____
Policy Number				

*If you do not select a PCP, one will be auto-assigned to you.

Section 6 | Conditions of Enrollment

On behalf of myself and the dependents listed in Section 5, I agree to or with the following:

1. I understand that my employer's application will determine coverage and that there is no coverage unless and until both the eligible-employee enrollment form and the employer application have been accepted and approved by Healthfirst.
2. I understand and agree that this enrollment form may be transmitted to Healthfirst or its agent by my employer or its agent.
3. The plan certificate of coverage will determine the rights and responsibilities of member(s). It will govern in the event they conflict with any benefits comparison, summary, or other description of the plan.

Section 7 | Misrepresentation

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Employee Signature: ______________________________ Date: _______ / _______ / _______

Section 8 | Acknowledgment and Signature

I consent to the release of any health information about me and my dependents for whom I can give consent, by our health care providers to Healthfirst and by Healthfirst to our health care providers, as reasonably necessary for Healthfirst or our providers to carry out treatment, payment, or health care operations. I agree that the information released for treatment, payment and health care operations may include confidential HIV, mental health and alcohol and substance abuse information about me and my dependents to the extent permitted by law. This consent will expire one year after the end of my enrollment with Healthfirst.

I represent that to the best of my knowledge and belief all information supplied in this form is true and complete. I have read, and I agree to, information listed on this Healthfirst Insurance Company, Inc. Small Group Employee Enrollment Form. I understand that if I do not sign this form within 30 days from the date first eligible or within 30 days of the qualifying life event (i.e., marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.), I will be considered a late enrollee, which may affect the effective date of coverage for me and my dependents. I am employed by the employer shown in Section 1, and I am working full time at least 20 hours per week for this employer at the regular place of business. I authorize Healthfirst to electronically transmit the information contained in this application. In addition, I consent to receive and/or communicate with Healthfirst electronically. I may withdraw my consent for electronic communication by contacting Member Services at the number on my ID card and request that future communication be sent in written form.

Employee Signature	Employee Email Address	Date (MM/DD/YYYY)
______________________	______________________	____ /____ /______