County Health Pool Enrollment Application

Welcome to County Health Pool (CHP). This is your Enrollment Application and Change Form.

Because we are dedicated to making the enrollment process easy for you, this form may be used to enroll in medical coverage as well as dental, vision, and life insurance coverage where available. This form may also be used to waive coverage, change information, cancel coverage or re-enroll. When completing this form, please follow the guidelines listed below. We appreciate the opportunity to serve you.

- **Complete all required information, and print legibly in all capital letters.** Inaccurate or illegible information will be returned, causing a delay in the application process.
- Be sure to read the entire application.
- If you have a dependent with a mental or physical disability, as certified by your dependent's physician, that physician must complete a Mentally/Physically Disabled Dependent Enrollment Request Form.
- Please contact your CHP benefits administrator if you have any questions about the form mentioned above, or if you need help in completing this application.

To enroll/open enrollment

- When enrolling for coverage for the first time, please complete sections 1–5 completely and section 6, if applicable.
- If you are in a relationship of Common Law Marriage, please read Section 8 and sign and date the enrollment application where requested.
- If you are in a relationship of Domestic Partnership please complete and attach the Domestic Partnership Affidavit.
- If enrolling due to special enrollment, County Health Pool will request legal proof of actual qualifying event. Such documents may include but are not limited to court orders, marriage certificates, domestic partnership affidavits, civil union registrations, and designated beneficiary agreements.
- After reading all areas of the application, read sections 7–10, and sign and date the enrollment application where requested.

To waive coverage

- To waive coverage for yourself, complete sections 1, 2, 3, 7 and 10, and sign and date the enrollment application where requested.
- Employees must still elect Basic Life AD&D in section 4 if waiving other coverage.

To change information

- If you need to make a change for yourself or one of your eligible dependents, please complete section 1. Be sure to include the date the change becomes effective.
- In section 3, please list all family members affected by the change. If you are changing your address, you may fill in your new address in this section.
- Indicate any other changes in the applicable areas of sections 2, 5 or 6.
- Read sections 7–10, and sign and date the enrollment application where requested.

After completing this form

- Read through the instructions above and make any required corrections. This will help ensure that your application is processed as quickly and accurately as possible.
- Promptly deliver your completed enrollment application to your CHP Entity Contact.

Thank you for choosing County Health Pool.
For more information about CTSI and its products and services, visit www.ctsi.org

County Health Pool Enrollment Application and Change Form

Medical, Dental, Vision, and Life

Check all coverage that applies: ☐ Medical ☐ Dental ☐ Vision ☐ Life

Social Security/Member no. (required[1]) (must be completed by employee)	Health group no. (must be completed by employer)	Dental group no. (must be completed by employer)	Division name

Section 1: Reason for completing application

☐ New enrollment ☐ Address/phone change ☐ Late entrant(s) ☐ Reinstate coverage ☐ Termination
☐ Beneficiary change ☐ Add/change/remove family member(s) ☐ Name change (previous name): ____________ ☐ Other: ____________

Qualifying event	Effective date of coverage (MM/DD/YYYY)	Date of qualifying event (MM/DD/YYYY)

Section 2: Benefits and coverage desired

Ask your employer for coverage available.

MEDICAL BENEFIT PLAN	MEDICAL COVERAGE FOR:	AMERITAS DENTAL COVERAGE FOR:	VISION COVERAGE FOR:
☐ PPO Plan A	☐ Employee	☐ Employee	☐ Employee
☐ Plan B1000	☐ Employee and spouse or child	☐ Employee and spouse or child	☐ Employee and spouse or child
☐ HDHP 2500	☐ Family	☐ Family	☐ Family
	☐ Decline and complete Waiver of Insurance (section 7)	☐ Decline	☐ Decline and complete Waiver of Insurance (section 7)

Section 3: Employee and family information – Use a separate sheet if needed.

List yourself and all eligible family members who are applying for or do not want coverage.
"Add" indicates the person is being added for coverage. "Change" indicates the person is changing coverage or personal information.
"Remove" indicates the person should no longer be covered.

☐ Add ☐ Change ☐ Remove	Employee last name	First name	M.I.	Gender ☐ Male ☐ Female	Birthdate (MM/DD/YYYY)	Relationship Self

Mailing street address for member correspondence	City	State	ZIP code

Home phone no.	Hire date (MM/DD/YYYY)	Date full-time (MM/DD/YYYY)	Hours worked/week	Earnings: $ ______ Per: ☐ Hour ☐ Week ☐ Year (complete only if Life/AD&D is based on earnings)

Cell phone no.	Full company name	Position title	Employee email address

☐ Add ☐ Change ☐ Remove	Spouse/Domestic Partner (DP) last name[2]	First name	M.I.	Gender ☐ Male ☐ Female	Birthdate (MM/DD/YYYY)	Relationship ☐ Spouse ☐ DP

If you and your spouse/DP have different last names, check the applicable box:
☐ Spouse (Statutory Marriage – if special enrollment, attach marriage certificate) ☐ Domestic Partnership (attach copy of Domestic Partnership Affidavit)
☐ Common-law Marriage – AVAILABLE ONLY IN THE STATE OF COLORADO (Complete Section 8) ☐ Civil Union (If Special Enrollment, attach Civil Union Registration)
Social Security no. (required[1])

☐ Add ☐ Change ☐ Remove	Dependent last name	First name	M.I.	Gender ☐ Male ☐ Female	Birthdate (MM/DD/YYYY)	Relationship

☐ Court-ordered Health Care Coverage (attach copy of court order)
☐ Mentally/Physically Disabled Dependent (attach Mentally/Physically Disabled Dependent form)
Social Security no. (required[1])

☐ Add ☐ Change ☐ Remove	Dependent last name	First name	M.I.	Gender ☐ Male ☐ Female	Birthdate (MM/DD/YYYY)	Relationship

☐ Court-ordered Health Care Coverage (attach copy of court order.)
☐ Mentally/Physically Disabled Dependent (attach Mentally/Physically Disabled Dependent form)
Social Security no. (required[1])

☐ Add ☐ Change ☐ Remove	Dependent last name	First name	M.I.	Gender ☐ Male ☐ Female	Birthdate (MM/DD/YYYY)	Relationship

☐ Court-ordered Health Care Coverage (attach copy of court order.)
☐ Mentally/Physically Disabled Dependent (attach Mentally/Physically Disabled Dependent form)
Social Security no. (required[1])

☐ Add ☐ Change ☐ Remove	Dependent last name	First name	M.I.	Gender ☐ Male ☐ Female	Birthdate (MM/DD/YYYY)	Relationship

☐ Court-ordered Health Care Coverage (attach copy of court order.)
☐ Mentally/Physically Disabled Dependent (attach Mentally/Physically Disabled Dependent form)
Social Security no. (required[1])

1 County Health Pool is required by the Internal Revenue Service to collect this information.
2 A person named as Domestic Partner (DP) under a Certificate of Registered Domestic Partnership.

Required: Employee Social Security no.

Section 4: Life insurance — Complete this section for Anthem Life Insurance Company coverage only. See your employer for available coverage.

Check applicable box:
☐ Group Term Life ☐ Dependent Life ☐ Supplemental Life employee amount: $_____ ☐ Supplemental Life spouse amount: $_____

Primary beneficiary last name	First name	M.I.	Social Security no.	Relationship
Primary beneficiary last name	First name	M.I.	Social Security no.	Relationship
Secondary beneficiary last name	First name	M.I.	Social Security no.	Relationship
Secondary beneficiary last name	First name	M.I.	Social Security no.	Relationship

Section 5: Other insurance

Have you or any of your dependents had any other health coverage in the last six months, or currently have coverage other than the applied-for coverage?
☐ Yes ☐ No
If Yes, please complete the section below for all covered members.

Member name (first, middle initial, last)	Type	Carrier	Begin (MM/DD/YYYY)	End (MM/DD/YYYY)
	☐ Medical ☐ Dental ☐ Vision ☐ Prescription			
	☐ Medical ☐ Dental ☐ Vision ☐ Prescription			
	☐ Medical ☐ Dental ☐ Vision ☐ Prescription			
	☐ Medical ☐ Dental ☐ Vision ☐ Prescription			

Section 6: Medicare coverage — Complete if you, your spouse/DP or dependent child(ren) have Medicare coverage. Use a separate sheet if needed.

Member name (first, middle initial, last)	Part A effective date (MM/DD/YYYY)	Part B effective date (MM/DD/YYYY)	Reason for disability if under age 65	Medicare claim no.

If indicating MEDICARE as primary, please attach letter to that affect.

Section 7: Waiver of insurance — Complete only if you do NOT want insurance coverage.

Check all who do **NOT** want insurance coverage ☐ Employee ☐ Spouse/DP ☐ Child(ren)

I/We do **NOT** want to participate in the group insurance plan, at this time, for the following reason(s):

☐ I/We have other group health insurance. List those covered elsewhere: _____

☐ I/We have other individual health insurance. List those covered elsewhere: _____

☐ I/We have other group dental insurance. List those covered elsewhere: _____

☐ I/We have other group vision insurance. List those covered elsewhere: _____

☐ I have no other insurance coverage and I am not interested at this time.

☐ I am retired from military service.
☐ I am a dependent of a uniformed or retired serviceman.

Signature — Required in Section 10

I hereby certify that I have been given the opportunity to participate in my Employer's Group Insurance Plan underwritten by the company(ies) indicated above. The plan has been explained to me and I decline to participate.

If I am declining enrollment for myself and/or my dependents (including my spouse/DP) because of other group or individual health insurance coverage, I may in the future be able to enroll myself and/or my dependents in this plan, provided that I request enrollment within 31 days after a qualifying event. In addition, if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

Required: Employee Social Security no.

Section 8: Common-Law Affidavit — Signatures required.

We the undersigned, being of lawful age, attest to the following facts:

- We have lived together continuously, in Colorado, as husband and wife from [ ] (MM/DD/YYYY) to the present.
- We are free to contract a valid ceremonial marriage, i.e., are not already married to someone else.
- We hold ourselves out as husband and wife, consent to the marriage, cohabit and have the reputation in the community as being husband and wife.
- We understand that a common-law marriage, in the state of Colorado, is valid for all purposes, the same as a ceremonial marriage, and can only be terminated by death or divorce.

Employee signature	Spouse signature	Date (MM/DD/YYYY)
X	X	

Section 9: Important legal information

The following applies to health plans, dental, vision or life coverage offered through County Health Pool and/or Anthem Life Insurance Company, (collectively called "the Plans"):

It is unlawful to knowingly provide false, incomplete, or misleading facts or information for the purpose of defrauding or attempting to defraud the Plan. Penalties may include imprisonment, fines, denial of coverage/insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported.

I hereby authorize my employer, until this authorization is revoked by notice in writing, to deduct in advance each month from the earned or accrued wages due me, such amounts as may be necessary to pay the rates which are currently in effect or shall be in effect in the future for coverage for which I am applying.

I certify that I work at least 30 hours per week, or at least 24 hours per week if my employer offers qualified part-time coverage, for the employer named on page one, if applying for coverage.

I certify each Social Security number listed on this application is correct.

Notice of pre-existing condition exclusion (Preexisting condition exclusion does not apply to policies that have been issued or renewed on or after 1/1/14.)

Section 10: Signature required

Please check one:

☐ I understand that the coverage for which I am applying is subject to eligibility requirements. I acknowledge that I have read all areas of this application and certify that I agree to all matters covered herein.

☐ I am waiving insurance coverage as indicated in Section 7.

Employee signature	Date (MM/DD/YYYY)
X	

Reset Form Save and Print