Trustmark benefits beyond benefits

First Health

Enrollment/Change Request

Plan Options – You MUST Select

Employer Group Control Number:	Employer Name UNIVERSITY OF DETROIT MERCY	☐ High Deductible Plan (HDHP)	☐ Base Plan	☐ Buy-up Plan

A. Type of Activity – Employee Complete Section A – D

Instructions: Refer to the instructions on the back before completing this form. You the employee must complete this application in full or it will be returned to you resulting in a delay in processing. You are solely responsible for its accuracy and completeness.	**Enrollment – Check One** ☐ New Enrollee/Subscriber Effective Date ___/___/___ ☐ Rehire/Reinstatement Effective Date ___/___/___ ☐ Open Enrollment ___/___/___ Date of Hire ___/___/___	**Change – Check all that apply** ☐ Add Spouse ☐ Add Dependent Child ☐ Name Change ☐ Other Date of Event ___/___/___	**Remove or Terminate - Check all that apply** ☐ Remove Spouse / Other ☐ Remove Dependent Child ☐ Employee Cancel Coverage/Contract

B. Employee Information Status ☐ Active ☐ Retired

Social Security Number	Name (Last, First, M.I)		Date of Birth	Gender ☐ M ☐ F
Home Address	Apt No	City, State	Zip Code	Telephone No.

C. Individuals Covered: List individuals for whom you are adding/changing/removing coverage

(A)dd (C)hange (R)emove	Name (Last, First, M.I)	Relations (Check)	Gender M - F	Birthdate MM / DD / YYYY	Social Security No. (Required)	Disabled Child Yes ✓
		☐ Spouse ☐ Partner	☐ ☐			☐
			☐ ☐			☐
			☐ ☐			☐
			☐ ☐			☐
			☐ ☐			☐
			☐ ☐			☐

If adding a Domestic Partner employee must complete an *Affidavit of Legally Domiciled Adults (LDA)*

D. Employee Signature

I certify that all information supplied in this form is true and complete to the best of my knowledge and/or belief. I have read and agree to the Conditions of Enrollment on the reverse side of this Enrollment/Change Request form.	*Employee Signature* **X**	*Date* ___/___/___	*Email Address*

Employee and Dependents Eligible for Continuation of Coverage (COBRA)

Employer use Only

COBRA For: ☐ Employee ☐ Dependents

Length ☐ 18 ☐ 36 ☐ Other _____

Date of Loss _____ Date Qualifying Event _____

Please fax to 313-993-1015 or Email HR@udmercy.edu

Created by UDM_9-2017

Instructions

Employer – Complete the **Employer Group Information** at the top of the form.

Employee – Complete Sections A - D

Plan Options: Select only an option offered by your employer.

Section A -Type of Activity:

- Check box(es) indicating reason(s) for submitting this Enrollment/Change Request.
- Provide Effective Date(s) and Date of Event(s) where requested.
  (If dates are unknown leave blank)

Section B- Employee Information:

- Complete **all** information in order for your Enrollment/Change Request to be processed.

Section C- Individuals Covered:

- Add/Change/Remove • Use "A", "C", or "R" to indicate whether you are adding, changing or removing coverage for an individual.
- Print your spouse/partner name along with the name(s) of your dependent(s), if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.
- Relationship Code Use **ONLY**: H=Husband, W=Wife, S=Son, D=Daughter, Y=Sponsored Male, X=Sponsored Female. **If the dependent is NOT your spouse or a biological or legally adopted child, please indicate relationship to employee in Special Remarks.**
- If a dependent is Disabled and financially dependent, check "Yes" and provide proof of handicapped status from the attending physician.

Section D - Employee Signature:

- Complete this section for all new enrollments or coverage changes.
- Employee must sign and date the Enrollment/Change Request in order for it to be processed.

Conditions of Enrollment

Applicant Acknowledgments and Agreements

On behalf of myself and the dependents listed on the reverse side, **I** agree to or with the following:

1. **I** acknowledge that by enrolling in a Trustmark plan coverage is underwritten or administered by Trustmark Health Benefits (referred to as "Trustmark").
2. **I** authorize deductions from my earnings for any contributions required for coverage and **I** agree to make any necessary payments as required for coverage.
3. **I** understand and agree that this Enrollment/Change Request may be transmitted to Trustmark or its agent by my employer or its agent. **I** authorize any physician, other healthcare professional, hospital or any other healthcare organization ("Providers") to give Trustmark or its agent information concerning the medical history, services or treatment provided to anyone listed on this Enrollment/Change Request form, including those involving mental health, substance abuse and HIV/AIDS. **I** further authorize Trustmark to use such information and to disclose such information to affiliates, providers, payors, other insurers, third party administrators, vendors, consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities. **I** have discussed the terms of this authorization with my spouse and competent adult dependents and **I** have obtained their consent to those terms. **I** understand that this authorization is provided under state law and that it is not an "authorization" within the meaning of the federal Health Insurance Portability and Accountability Act. This authorization will remain valid for the term of the coverage and so long thereafter as allowed by law. **I** understand that **I** am entitled to receive a copy of this authorization upon request and that a photocopy is as valid as the original.
4. The plan documents will determine the rights and responsibilities of member(s) and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.

Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive 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 subjects such person to criminal and civil penalties.

Attention Arkansas and West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application is guilty of a crime and may be subject to fines and confinement in prison.

Attention Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of 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 to the Colorado division of insurance within the department of regulatory agencies.

Attention Kentucky Residents: 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 may subject such person to criminal and civil penalties.

Attention Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.