Hometown Health

Enrollment / Change Form

Hometown Health Use Only

G#
M#
L
F,M

Human Resources Only

Employer_____ Group#_____ Effective Date_____
Employee's Weekly Hours_____ Employee's Date of Hire_____ Employer Signature_____

Employee Information

Name (Last)	(First)	(M.I.)	Social Security Number
			___-___-____

Mailing Address (Street or P.O. Box)	City	State	Zip Code	County

Physical Address	City	State	Zip Code	County

Date of Birth	Marital Status	Occupation	Home Phone	Work Phone
____/____/____	Married ❑ Single ❑ Divorced ❑ Widowed ❑		( )____-____	( )____-____

Plan Elected

❑ HMO ❑ EPO ❑ PPO ❑ PPO w/HSA* *Street Address only, no P.O. Boxes

Plan Elected_____ Plan Elected_____ Plan Elected_____ Plan Elected_____

Other Medical Coverage:

Do you or any of your Dependents listed below have Medical/Health Insurance (Including Medicare/Medicaid)?

❑ Yes ❑ No
If yes, please provide copy of insurance card (front & back)

Contract Termination Only

Completion of this section will terminate coverage for subscriber and all dependents.

❑ Left Company ❑ Moved ❑ Dissatisfied
❑ Deceased ❑ Ineligible ❑ Other_____

Reason for Change

❑ New Hire
❑ Name
❑ Annual Election
❑ Rehire
❑ Other_____
❑ COBRA (18-29-36)
❑ PT/FT
❑ Reinstatement
❑ Waive Coverage
❑ Retiree
❑ Transfer
❑ Address

Plan Change: From:_____To:_____

Add/Delete Dependent

*❑ Marriage *❑Divorce
*❑Birth/Adoption *❑Other
*❑Loss of Dependent Status *❑Court Ordered/Legal Guardianship
*❑ Loss of Insurance *❑Deceased
* Attach legal documentation as proof of event.

Member Information – Complete with new or change information

Action	*(Last) (First) (M.I.)	Social Security Number	Birth Date Mo./Day/Yr.	Sex M/F	Reside with Emp.? Y/N	**PRIMARY CARE PHYSICIAN (if required)
Add ❑ Change ❑ Delete ❑	Employee:				-	
	Email Address:					
Add ❑ Change ❑ Delete ❑	Spouse					
	Email Address					
Add ❑ Change ❑ Delete ❑	Dependent Child (Relationship)					
	This Shaded Space For Hometown Health Use Only					
Add ❑ Change ❑ Delete ❑	Dependent Child (Relationship)					
	This Shaded Space For Hometown Health Use Only					
Add ❑ Change ❑ Delete ❑	Dependent Child (Relationship)					
	This Shaded Space For Hometown Health Use Only					
Add ❑ Change ❑ Delete ❑	Dependent Child (Relationship)					
	This Shaded Space For Hometown Health Use Only					

** It is member's responsibility to verify physician availability in their area.

Revised Aug. 2022

ACKNOWLEDGEMENT OF TERMS Employee Signature X_____Date_____
(SEE REVERSE SIDE)

Acknowledgement of Terms

I understand and agree that, with the exception of emergency procedures, all services must be performed by a Hometown Health participating provider, or authorized in advance by Hometown Health, to be considered for payment at the in-network rate. Additional requirements may apply. See the appropriate plan documents for details.

I understand that I am responsible for paying any required deductibles, copayments, and coinsurance directly to the providers of healthcare at the time of service.

I agree to be bound by all terms of the plan under which I am applying for coverage for as long as I am covered under the plan.

I certify that, to the best of my knowledge, the information shown on the front of this form is correct.

I have read and understand the terms of this application.

My signature on the front of this form constitutes acceptance of the terms listed above.

Key to plan types:
HMO: Health Maintenance Organization
PPO: Preferred Provider Organization
TPA: Third Party Administrator for self-funded plan
HSA: Health Savings Account

Statement of Accountability

To be completed only when the applicant cannot complete the application
Note: Translator must be 18 years or older to translate the application on behalf of the applicant

I, _____, personally read and completed this Individual Application for the applicant named below because:

❑ Agent assisted application ❑ Applicant does not read English ❑ Applicant does not speak English
❑ Applicant does not write English ❑ Other (explain)_____

I translated the contents of this form and to the best of my knowledge obtained and listed all the requested personal and medical history disclosed by the:

❑ Applicant ❑ Or by:_____

I also translated and fully explained the "Application Understandings, Conditions and Agreement," and "Payment Method."

_____
Translator Signature (Required) Date (Required)

I confirm that the application was translated on my behalf.

_____
Applicant Signature (Required) Date (Required)

Language interpreted (e.g. Spanish):