FAMILY ADVANTAGE HEALTH PLAN (FAHP): ENROLLMENT FORM

☐ New ☐ Change ☐ Termination (date: _____)

ELIGIBILITY INFORMATION	PROGRAM INFORMATION
▪ You (the employee) and/or any dependents (spouse/children) must have been covered under your employer's medical plan for the 12 months prior to the new Plan Year effective date, or have been enrolled in the FAHP during the previous Plan year to be eligible. ▪ You (and/or your eligible dependents) **must be covered** by your spouse's, your parent's, or any other accessible employer group medical plan to be eligible; that group medical plan will henceforth be referred to as the "Primary Medical Plan". ▪ The Primary Medical Plan: – must be an employer-sponsored group health plan, not through Medicare, Medicaid, Tricare, a Limited Benefits Plan, an Individual Policy, a Stand-Alone HRA, or a Short-Term Policy. – must not include active contributions into a Health Savings Account (HSA).	▪ By enrolling you and/or your eligible dependents in this FAHP, you will be 100% reimbursed for the deductibles, copays, and coinsurance of the Primary Medical Plan. ▪ You may use your FAHP HRA benefits debit card for payment towards eligible expense, or complete and submit a Reimbursement Request Form with claim documentation to BCC; all expenses over $1,000 require a Reimbursement Request Form be submitted; filing deadlines apply (refer to FAHP Plan Documents for deadline information). ▪ This FAHP is set to the ACA allowable maximums determined by the IRS; however, reimbursement can only be made for up to the Out of Pocket Maximums of the Primary Medical Plan; please refer to your Primary Medical Plan's SPD for these amounts.

SECTION 1: EMPLOYER INFORMATION

EMPLOYER NAME:		PLAN YEAR:	

SECTION 2: EMPLOYEE INFORMATION

FIRST NAME:		MIDDLE INITIAL:		LAST NAME:			
EMAIL ADDRESS:		PHONE NUMBER:		HIRE DATE:			
STREET ADDRESS:		CITY:		STATE:		ZIP CODE:	
ENROLLING FOR:	☐ Self Only ☐ Spouse Only ☐ Child(ren) Only ☐ Self & Spouse ☐ Self & Child(ren) ☐ Spouse & Child(ren) ☐ Self & Family						

SECTION 3: PARTICIPANT & DEPENDENT ENROLLMENT INFORMATION

RELATIONSHIP	NAME			DATE OF BIRTH *(mm/dd/yyyy)*	SSN	GENDER		IS THIS PERSON MOVING TO THE PRIMARY MEDICAL PLAN & ENROLLING IN FAHP?
	FIRST	MI	LAST			MALE	FEMALE	
SELF/EMPLOYEE	*see employee information above*					☐	☐	☐ YES ☐ NO
☐ SPOUSE						☐	☐	☐ YES ☐ NO
☐ CHILD UNDER 26 ☐ DISABLED CHILD						☐	☐	☐ YES ☐ NO
☐ CHILD UNDER 26 ☐ DISABLED CHILD						☐	☐	☐ YES ☐ NO
☐ CHILD UNDER 26 ☐ DISABLED CHILD						☐	☐	☐ YES ☐ NO

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☐ CHILD UNDER 26 ☐ DISABLED CHILD						☐	☐	☐ YES ☐ NO
☐ CHILD UNDER 26 ☐ DISABLED CHILD						☐	☐	☐ YES ☐ NO
☐ CHILD UNDER 26 ☐ DISABLED CHILD						☐	☐	☐ YES ☐ NO
☐ CHILD UNDER 26 ☐ DISABLED CHILD						☐	☐	☐ YES ☐ NO

SECTION 4: SPOUSE, PARENT, OR OTHER PRIMARY MEDICAL PLAN INFORMATION

EMPLOYER NAME:		**CARRIER:**		**PLAN NAME:**	
DEFFERED ENROLLMENT/LATE ENTRY DATE: *If the Primary Medical Plan will not allow enrollment until a future date, your FAHP enrollment will be delayed. Please identify the date in which enrollment into the Primary Medical Plan will be allowed:*					

SECTION 5: AUTHORIZATION

I hereby authorize my employer to enroll me into the employer-sponsored Family Advantage Health Plan. I agree to comply with the terms and conditions of the Plan. I understand that I may only submit claims that are considered allowable expenses under the Primary Medical Plan, and that all premium reimbursements will be included in my normal payroll disbursement and will be reported as taxable wages on my W-2. I also understand that I may not make or receive any HSA contributions while enrolled in this Plan. I agree to use the FAHP debit card provided to me for only eligible expenses that comply with the terms and conditions of the Plan.	**EMPLOYEE SIGNATURE:**	
	DATE:	

PLEASE SEND YOUR COMPLETED/SIGNED ENROLLMENT FORM AND ENROLLMENT AFFIDAVIT TO YOUR HR DEPARTMENT.

FAMILY ADVANTAGE HEALTH PLAN

BCC TO COMPLETE:			
EFFECTIVE DATE OF FAHP:		**BCC INITIALS:**	
ORIGINAL EFFECTIVE DATE OF THE ER GROUP HEALTH PLAN:		**DATE:**	
I confirm that this employee and all dependents requested to be enrolled in our FAHP above have moved to the PRIMARY Health Plan and are no longer on the Employer's group health plan.			