Prominence[SM]
Health Plan
Formerly Saint Mary's Health Plans

For office use only:
Group #:____________ Effective Date:____________ By:____________

MEMBER ENROLLMENT/CHANGE AND TERMINATION FORM

PLEASE PRINT – Plan Selected:

☐ HMO/POS ____________ ☐ PPO ____________ ☐ HD ____________ ☐ Dental ____________ ☐ Waive coverage

Note: For an accurate name of your Prominence Health Plan medical and/or dental plan, please refer to your summary of benefits documents. *(please complete Sections A & H only)*

Please check as appropriate: ☐ Open Enrollment ☐ New Hire ☐ New Enrollee ☐ Domestic Partner ☐ COBRA

☐ New Application Effective Date ____/____/____ ☐ Address Change Qualifying Event____________

☐ Remove Dependent Term Date ____/____/____ ☐ Name Change ____________

☐ Add Dependent Event Date ____/____/____ ☐ PCP Change Date of Qualifying Event ____/____/____

☐ Terminate Coverage Term Date ____/____/____ ☐ Other: ____________ ______ 18 ______ 29 ______ 36 months

A. SUBSCRIBER INFORMATION – PLEASE PRINT CLEARLY, USING BLACK INK

EMPLOYEE

Name (Last, First, Middle Initial)				☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed	
Home Address (Street)	Apt. #	City, State	Zip	Home Phone Number	Primary Language Spoken
Mailing Address (if different from above)	Apt. #	City, State	Zip	E-mail Address	
Employer Name				Department / Site	
Date of Hire (Mo/Day/Yr)	Work Phone Number	☐ Full Time ☐ Part Time		No. Hours Worked Per Week	
Job Title	No. of Dependents	Type of Coverage Elected: ☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Employee & Family			

B. INDIVIDUALS COVERED – MEDICAL/DENTAL COVERAGE

If waiving health and dental coverage, please complete Section H. ☐ *This is an employee-only group health plan. It does not provide dependent coverage.*

Name (Last, First, Middle Initial) *(List only family members to be insured, removed, or changed)*	Social Security Number	Gender	Date of Birth *(mo/day/yr)*	Primary Care Physician Group	Primary Care Physician Name	Check if now a patient	Please check if enrolling in coverage for: Medical	Dental	Both
#1-Employee		☐ M ☐ F				☐	☐	☐	☐
#2-Spouse		☐ M ☐ F				☐	☐	☐	☐
#3-Dependent		☐ M ☐ F				☐	☐	☐	☐
#4-Dependent		☐ M ☐ F				☐	☐	☐	☐
#5-Dependent		☐ M ☐ F				☐	☐	☐	☐
#6-Dependent		☐ M ☐ F				☐	☐	☐	☐

If you are providing additional sheets, check here ☐ and insert the sheets before sealing this Enrollment Form.

C. OTHER INSURANCE

After enrolling with Prominence Health Plan, will you or your dependents (if covered under this group plan) have any other insurance? ☐ Yes ☐ No
If yes, please provide the following information:

C1. OTHER INSURANCE-COVERED INDIVIDUALS – *If additional space is needed, please attach a separate sheet, sign, and date the sheet*

Name of Covered Individual *List only family members that will have other insurance coverage at the time of enrollment*	Carrier Name	Carrier Phone Number	Effective date	Policy Number	Group Number	Policy Holder	Policy Holder Date of Birth

C2. MEDICARE COVERED INDIVIDUALS

Name (Last, First, Middle Initial)	Coverage *(select both if applicable)*	Effective Date	Policy Number	Disabled	Retired
	☐Medicare A ☐ Medicare B			☐ Yes ☐ No	☐ Yes ☐ No
	☐Medicare A ☐ Medicare B			☐ Yes ☐ No	☐ Yes ☐ No
	☐Medicare A ☐ Medicare B			☐ Yes ☐ No	☐ Yes ☐ No
	☐Medicare A ☐ Medicare B			☐ Yes ☐ No	☐ Yes ☐ No

D. CONDITIONS OF ENROLLMENT:

On my behalf and for my enrolled dependents, I hereby (1) apply for healthcare coverage through Prominence Health Plan (2) agree to abide by all policies and procedures of Prominence Health Plan including eligibility, benefits, exclusions, limitations and other terms of the Certificate of Coverage or the Evidence of Coverage; (3) authorize any physician, hospital or other healthcare provider to release to Prominence Health Plan any and all medical information and records as requested for the administration and management, as well as for medical purposes, (4) to cooperate with and provide any and all consent, releases and other assignments necessary for Prominence Health Plan to coordinate the benefits of this and any other insurance or coverage; and (5) to make required copayments as detailed in the Certificate of Coverage or the Evidence of Coverage and Summary of Benefits.

If coverage is approved and accepted, I authorize any payroll deduction necessary for the coverage that I have elected. I certify that the above information is correct to the best of my knowledge and belief. I agree that a copy of this authorization shall be valid as the original.

I hereby represent that the answers given above are correct to the best of my knowledge and belief. I understand that the information, which I have supplied along with any information requested from medical providers, may be used in determining whether coverage will be available. I understand that any material misstatements or failure to provide requested information may result in coverage not being offered. Such misstatement or failure to provide information may also result in coverage for my group being terminated. Any materially false, fictitious, or fraudulent statements or representations may result in Federal fines or imprisonment of not more than 5 years or both.

E. AUTHORIZATION:

I authorize any physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, or consumer reporting agency or employer having information available as to diagnosis, treatment or prognosis with respect to any physical or mental condition including information relating to drugs and/or alcoholism and/or treatment of me or my minor children and any other non-medical information regarding me or my minor children to provide to Prominence Health Plan any and all such information.

I understand that the information obtained by use of this Authorization will be used by Prominence Health Plan to determine whether Health Plans will offer the group, through which I am applying, coverage. Any information obtained by Health Plans will be kept strictly confidential and will not be used for any purpose other than to determine whether to provide such coverage.

1) I KNOW that I may request a copy of this authorization.
2) I AGREE that a photographic copy of this authorization shall be as valid as the original.
3) I AGREE that this authorization shall be valid for a period to two and one half years from the date shown below.

Employee Signature ____ Date ______________________

☐ If applicable, I acknowledge that I am enrolling in a group health plan which covers myself as an employee only and does not include coverage for any dependents, either a spouse or children.

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www.prominencehealthplan.com | 775.770.9300 or 800.863.7515

Approval Date: 04/16/2014
Effective Date: 04/16/2014

F. SPECIFIC AUTHORIZATION TO PARTICIPATE IN MEDIATION AND ARBITRATION

Both you and all dependents covered under the plan (hereinafter "you") and Prominence Health Plan (collectively, the "parties") specifically authorize and agree to resolve any and all disputes, claims or controversies arising out of or relating to the plan through mediation, and if the mediation is not successful, through binding arbitration before initiating a civil lawsuit in a court of general jurisdiction.

Arbitration is more informal than a lawsuit in court. Arbitration uses a neutral arbitrator instead of a judge or jury, allows for more limited discovery than in court, and is subject to very limited review by courts. Arbitrators can award the same damages and relief that a court can award. Any arbitration under this mediation/arbitration agreement will take place on an individual basis; class arbitrations and class actions and consolidations of multiple individual's claims are not permitted. Prominence Health Plan agrees to pay for the arbitrator's or mediator's fees and expenses.

Prominence Health Plan and you agree to arbitrate all disputes and claims between us including, but not limited to any dispute, claim or controversy arising out of or relating to the plan, including any claim for benefits, statutory violation, breach of fiduciary duty, enforcement, interpretation or validity of claims ("covered claims"), including the determination of the scope or applicability of this mediation/arbitration agreement.

You may reject this mediation/arbitration agreement by signing Section G below.

You may also reject this mediation/arbitration agreement by sending Prominence Health Plan written notice to the notice address provided in the plan within thirty (30) days of either: (1) the date on which you first receive notice of the plan containing this mediation/arbitration agreement or (2) the last day of the first annual enrollment period following the date your first receive notice of the plan containing this mediation/arbitration agreement.

I specifically authorize and agree on behalf of myself and all Dependents covered under the Plan to participate in Mediation and Arbitration.

Employee Signature: ______________________________ Date (Month/Day/Year): ______________________

G. DECLINATION OF RIGHT TO MEDIATION AND ARBITRATION– *to be completed if mandatory mediation and arbitration is declined or refused by an eligible employee and/or their eligible family members*

1. Mediation and Arbitration Declined For: ☐ Myself ☐ Spouse/Domestic Partner ☐ Dependents	The individuals checked in box G.1. do not want to participate in mediation and arbitration. I have read Section F above and I waive the rights of the individuals checked in box G.1. to participate in mediation and arbitration.

I acknowledge I am declining to arbitrate and mediate disputes, claims or controversies arising out of or relating to the Plan.

Please sign here ONLY if you are declining to agree to Mediation and Arbitration.

Employee Signature: ______________________________ Date (Month/Day/Year): ______________________

H. DECLINATION/WAIVER OF COVERAGE – *to be completed if medical and/or dental coverage is declined or refused by an eligible employee and/or their eligible family members*

1. Medical Coverage Declined For: ☐ Myself ☐ Spouse/Domestic Partner ☐ Dependents	Reason for Declining Coverage (if applicable, please attach front/back of your Health coverage ID card.) ☐ Covered by spouse/domestic partner's group coverage – Carrier Name and ID ______________________________
2. Dental Coverage Declined for: ☐ Myself ☐ Spouse/Domestic Partner ☐ Dependents	☐ Enrolled in other Insurance Carrier Plans – Carrier Name and ID ______________________ ☐ Spouse/Domestic Partner covered by employer's group medical coverage
3. Coverage Declined for: ☐ Without insurance at this time ☐ I am covered under my spouse's plan	☐ Spouse/Domestic Partner covered by employer's group dental coverage ☐ Medicare ☐ Covered by TRICARE or CHAMPVA ☐ AHCCCS ☐ Indian Health Services ☐ Other (Explain) ______________________

I acknowledge I have been given the right to apply for this coverage, however, I am electing not to enroll. By declining this group coverage I acknowledge that myself and/or my dependents may have to wait until the plan's next anniversary date to be enrolled for group coverage.

Please sign here ONLY if you are declining coverage for yourself or dependents(s)

Employee Signature: ______________________________ Date (Month/Day/Year): ______________________