

# BUTLER HEALTH PLAN

# ENROLLMENT/CHANGE FORM

Group # A08103 for Allied Benefit Systems

<b>1. EMPLOYEE INFORMATION</b>					
Last Name		First Name		M.I.	SS# - -
Address Apt#		City		State	Zip
Home Phone ( )		Work Phone ( )		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
E-mail		Employer		Location	
				Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed

<b>2. PLAN SELECTION</b>		<b>Check box to enroll in selected plan.</b>			
<b>Medical Plan</b>		<input type="checkbox"/> Employee <input type="checkbox"/> Choice <input type="checkbox"/> Employee + 1 <input type="checkbox"/> Classic <input type="checkbox"/> Family <input type="checkbox"/> Basic		<b>Dental Plan</b>	
				<input type="checkbox"/> Employee <input type="checkbox"/> Employee + 1 <input type="checkbox"/> Family	

**IF WAIVING MEDICAL AND/OR DENTAL COVERAGE YOU MUST COMPLETE AND SIGN SECTION 8**

<b>3. CHANGE (Qualifying Event)</b>		Effective date of change: / /			
Check reason for change: <input type="checkbox"/> Newborn <input type="checkbox"/> Adoption <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Child no longer eligible					
<input type="checkbox"/> Change in spouse's employment or insurance coverage <input type="checkbox"/> Change in dependent status-State reason:					

<b>4. FAMILY INFORMATION</b>		<b>List covered dependents. Check this box <input type="checkbox"/> if attaching list of additional dependents.</b>					
Relationship	Dependent First Name MI Last Name Social Security Number (SS#)	Sex	Birth Date Mth/Day/Year	Child resides with you?	Child is your IRS dependent?	Full Time Student?	Check coverage that apply:
Spouse	Name _____ SS# - -	<input type="checkbox"/> M <input type="checkbox"/> F	/ /				<input type="checkbox"/> Medical <input type="checkbox"/> Dental
<input type="checkbox"/> Natural <input type="checkbox"/> Adopted <input type="checkbox"/> Step <input type="checkbox"/> Court Order	Name _____ SS# - -	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental
<input type="checkbox"/> Natural <input type="checkbox"/> Adopted <input type="checkbox"/> Step <input type="checkbox"/> Court Order	Name _____ SS# - -	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental
<input type="checkbox"/> Natural <input type="checkbox"/> Adopted <input type="checkbox"/> Step <input type="checkbox"/> Court Order	Name _____ SS# - -	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental
<input type="checkbox"/> Natural <input type="checkbox"/> Adopted <input type="checkbox"/> Step <input type="checkbox"/> Court Order	Name _____ SS# - -	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental
<input type="checkbox"/> Natural <input type="checkbox"/> Adopted <input type="checkbox"/> Step <input type="checkbox"/> Court Order	Name _____ SS# - -	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental

## 5. OTHER MEDICAL/RX COVERAGE

Is your spouse employed?  Yes  No

Is your spouse enrolled in his/her employer-sponsored medical plan?  Yes (If "Yes," complete the rest of Section 5 - Other Medical/Rx Coverage.)  
 No (If "No," you must complete a COB Questionnaire.)

Name and Address of Employer

Name of Medical Insurance or TPA Policy Number

Address of Medical Insurance or TPA City State Zip

List your spouse & dependents with other Medical/Rx coverage. Use the following codes to indicate other coverage for dependents enrolled in BHP.

- 1) Employer Provided Medical/Rx
- 2) Retirement Plan Medical/Rx
- 3) TriCare Military Coverage
- 4) Parent Court Order
- 5) Medicare/Medicaid
- 6) Other (Attach Explanation)
- 7) No other coverage

Name	Other Medical	Other Rx Coverage

Please Complete Reverse Side

<b>6. OTHER DENTAL COVERAGE</b>		Do you or any of your family members have other group dental insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, Name of Dental Policy Holder		SS# - -	
Name of Dental Insurance or TPA	Policy Number		
Address of Dental Insurance or TPA	City	State	Zip
List Dependents Covered:			

**7. SIGNATURE REQUIREMENT - READ AND SIGN**

Any person who knowingly and with intent to defraud, files a statement containing any materially false information or conceals, for the purpose of misleading information concerning any fact material thereto, commits fraud which is a crime and could jeopardize your coverage.

I hereby consent and authorize any dentist, physician, supplier, hospital, pharmacy, insurance company, employer or organization to disclose any medical information concerning myself or my dependents to the Butler Health Plan or its agents or contractors for the purpose of administering, supervising and monitoring the health Plan(s). I further consent to the subsequent disclosure of medical information concerning myself or dependents by Butler Health Plan or its agents or contractors to contractors who provide wellness, disease management, case management or other health and health care related services to Butler Health Plan and/ or its participants. This consent shall be valid until revoked in writing by the employee.

Employee Signature	Date
Print Employee Name	

**8. WAIVER OF COVERAGE- READ AND SIGN IF YOU REFUSE COVERAGE FOR YOURSELF AND DEPENDENTS.**

- Waive medical coverage due to:  Have other medical coverage or  Other (Please explain) \_\_\_\_\_
- Waive dental coverage due to:  Have other dental coverage or  Other (Please explain) \_\_\_\_\_

**I understand, if in the future I decide to apply for group medical benefits, additional limitation and waiting periods may apply.**

Employee Signature	Date
Print Employee Name	

**REQUIRED LEGAL DOCUMENTATION**

Dependent Type	Submit Copy of Preferred Documentation	Alternate Document
Spouse	Marriage certificate	In case "Preferred Documentation" is not available, you may use your most recent tax return with the financial information blacked out in order to prove dependent status.
Birth Child Under Age 19	Birth certificate	
Adopted Child Under Age 19	Adoption certificate	
Legal Guardianship for Child Under Age 19	Proof of legal guardianship	
Child Age 19-25 Who is a Full Time Student	1. Appropriate documentation as listed above for birth, adopted or legal guardian status <b>AND</b> 2. One of the following from the current school term to demonstrate full-time student status: Grade report, school registration, transcripts or letter from school showing full time student status.	
Stepchild	Divorce decree identifying medical coverage for dependents	
Handicapped Child Over Age 19	Please obtain a "Certificate of Disability for Handicapped Child."	
How to Waive Pre-existing Conditions - Some or all of the pre-existing condition waiting period may be waived under the terms of the HIPAA Act of 1996.	A Certificate of Credible Coverage or other documentation of prior health coverage for you and your dependents must be attached or forwarded to the Butler Health Plan Claim Administrator, Allied Benefit Systems.	

<b>TO BE COMPLETED BY EMPLOYER:</b>	<b>Effective Date of Change:</b> / /	<b>Date of Hire:</b> / /
<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Cancellation	<input type="checkbox"/> Name Change
<input type="checkbox"/> Re-Enrollment	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Address Change
<input type="checkbox"/> Dependent Status Change-State Reason:	<input type="checkbox"/> Other-State Reason:	