FHA-TPA
Benefit Administrators

ENROLLMENT/CHANGE FORM
(Please Print)

Reason for Submission: **Effective Date:**_____

☐ Initial Application ☐ Change of Dependent ☐ Change of Name ☐ Change of Plan

☐ Change of Salary ☐ Change of Beneficiary ☐ Other _____

☐ Terminations: Reason for Termination _____ Termination Date:_____

☐ Termination of Employment ☐ Termination of Benefit

☐ Termination of Dependent Coverage: Dependent Name:_____Termination Date:_____

Company Name (Employer):_____ **Location (If different):**_____

Name (Last) (First) (Middle)

Address (Street) City State (Zip Code)

Social Security No._____–_____–_____ Date of Birth:_____

Marital Status:_____ Sex:_____ Hire Date:_____

Telephone: ( ) _____ E-Mail:_____

Beneficiaries:

Primary_____ Relationship:_____

Contingent_____Relationship:_____

Benefit Information

☐ PPO ☐ EPO ☐ POS

Coverage:	Medical	Dental
EE Only	☐	☐
EE & Spouse	☐	☐
EE & Child	☐	☐
EE & Family	☐	☐

Life Insurance Coverage

Yearly Salary_____

Class_____

List All Family Members electing Dependent Coverage:

Last Name	First Name	MI	Social Security No.	Relationship	Sex	Date of Birth

Employee Certification: I declare that in the best of my knowledge and belief, all of the statements and answers given above are correctly. I have read my enrollment rights on the reverse side of this form.

COMPLETE **ONLY** WHEN APPLICABLE

I authorize my employer to deduct insurance premiums from my paycheck on a weekly/bi-weekly/monthly basis in the amount of $_____, beginning with pay period ending_____.

Employer's Signature: X_____ **Date:**_____

Employer's Signature: X_____ **Date:**_____

FHA-TPA Approved by:_____ **Date:**_____

See Back Important Notice Of Your Rights **Distribution:** White *FHA* Yellow: *Employer* Pink: *Employee*

IMPORTANT NOTICE OF YOUR ENROLLEMNT RIGHTS

DOCUMENTATION OF HEALTH COVERAGE

The Health Insurance Portability and Accountability Act. of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for medical conditions present before you enroll.
Under the law preexisting condition exclusion normally may not be imposed for more than 12 months (18 for a late enrollee). The 12 months (or 18 months) exclusion period may be reduced by your prior health coverage. You are entitled to a certificate from your prior plan that will show evidence of your prior health coverage.

SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within **"30 days"** after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within **"30 days"** after the marriage, birth, adoption, or placement adoption.

To request special enrollment or obtain more information, contact: Your human resources department representative or:

FHA-TPA Benefit Administrators
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Phone: (954) 366-0111 • Toll free #: (800) 707-0501 • Fax: (954) 366-0133