Rv. 6/2019

Universal Benefit Form
Medical, Prescription, Vision, Dental, COBRA

Group Name: Manheim Township

1.SUBSCRIBER INFORMATION:

☐ ENROLLMENT ☐COVERAGE CHANGE☐ TERMINATION ☐ ADDRESS/NAME CHANGE

MEDICAL GROUP NUMBER: **CLASS :** **(DEPENDENTS UP TO AGE 26)**
DENTAL GROUP NUMBER: **OPTION:** **(DEPENDENTS UP TO AGE 26)**
VISION GROUP NUMBER: **OPTION:** **(DEPENDENTS UP TO AGE 26)**

CHECK REASON CODE BOX ON REVERSE PAGE THAT APPLIES TO THE BOXES BELOW
☐ OPEN ENROLLMENT
☐ INITIAL ELIGIBILITY
☐ LIFE CHANGE EVENT
Effective Date of Change:

Subscriber Card ID or Social:	Birth Date	■ Male ☐ Female	☐ Single ☐ Married ☐ Domestic Partner
Subscriber Last Name	**Subscriber First Name**		**MI**

Does Employer employ 20 or more employees? ■ Yes ☐ No

☐TERMINATION
☐ COBRA Qualifying Event

Effective Termination Event Date:

Effective Date Benefits End:
(Per Plan Document)

MAILING ADDRESS (Include street address, City, State & Zip Code):

*Street:*_____ *Phone(_____)*_____
*City:*_____*State:*_____*ZIP:*_____ *New Address* ☐ Yes ☐ No

Employment Status:
☐ Active (Full-Time) ☐ Retired – Date _____ ☐ Other – Explain _____

DATE HIRED:
EFFECTIVE DATE:
Has the Waiting Period Been met? ☐ Yes ☐ No

2. ENROLLMENT/CHANGE INFORMATION:

3. COVERAGE SELECTION/CHANGE (A to ADD, R to REMOVE)

4. PRIMARY CARE PHYSICIAN

First Name & Middle Initial (Show Last Name if different from Subscriber.	Soc Security #	Birth Date	ADD or REMOVE?	PPO	HDHP	HMO	Senior	Drug	Dental	Vision	Indicate Practice Names & Codes Refer to Applicable Provider Directory — REQUIRED FOR HMO ONLY
SUBSCRIBER:		__/__ _/____	☐ Add ☐ Remove	☐	☐	☐	☐	☐	☐	☐	Current Patient ☐ Yes ☐ No PCP Code #
Spouse: ☐ Male ☐ Female		__/_ __/____	☐ Add ☐ Remove	☐	☐	☐	☐	☐	☐	☐	Current Patient ☐ Yes ☐ No PCP Code #
☐ Son ☐ Dau		__/__/____	☐ Add ☐ Remove	☐	☐	☐	☐	☐	☐	☐	Current Patient ☐ Yes ☐ No PCP Code #
☐ Son ☐ Dau		__/__ _/____	☐ Add ☐ Remove	☐	☐	☐	☐	☐	☐	☐	Current Patient ☐ Yes ☐ No PCP Code #
☐ Son ☐ Dau		__/_ __/____	☐ Add ☐ Remove	☐	☐	☐	☐	☐	☐	☐	Current Patient ☐ Yes ☐ No PCP Code #
☐ Other		__/_ __/____	☐ Add ☐ Remove	☐	☐	☐	☐	☐	☐	☐	Current Patient ☐ Yes ☐ No PCP Code #

5. FSA INFORMATION:

Is the member enrolled in a Flexible Spending Account (FSA)? ☐ Yes ☐ No
IF YES WHAT IS THE MONTHLY CONTRIBUTION AMOUNT $

6. MEDICARE COVERAGE INFORMATION

Complete Medicare Information for Subscriber and/or Dependents CURRENTLY enrolled for Medicare. (Refer to your red, white, and blue Medicare Health Insurance Card for the Medicare Claim Number and effective dates.

Name of Subscriber or Dependent	*Medicare Claim Number*	*Effective Dates Hospital (Part A)*	*Effective Dates Medical (Part B)*	*Disabled?*	*ESRD?*	*Age*
		/ /	/ /	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
		/ /	/ /	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

7. HANDICAPPED DEPENDENTS	8. OTHER INSURANCE COVERAGE		
Name of Handicapped Dependent	*Complete if YOU or ANY OF YOUR DEPENDENTS have health care coverage with **any other** insurance company. If completed, you may receive additional information. (Please attach a separate sheet of paper if additional space is needed).*		
	Name of Subscriber or Dependent	***Name of Health Care Plan/Insurance Co.***	***Identification/Policy Number***

9. CHANGE THE FOLLOWING INFORMATION	Change is for ◯ Subscriber ◯ Dependent		10. STATEMENT OF APPLICATION
Name	*From*	*To*	***By signing this application, I am indicating that I have read the statement of application on the back of the form. I verify that the information given is true and correct.***
Birth Date	*From* _____/_____/_____	*To* _____/_____/_____	
Social Security Number	*From* ___ ___ ___/___ ___/___ ___ ___ ___	*To* ___ ___ ___/___ ___/___ ___ ___ ___	_____ _____ ***Subscriber's Signature*** ***Date***

11. REASON CODES

INITIAL ELIGIBILITY
- ☐ New group enrollment and/or group medical only benefit change.
- ☐ Newly hired – The applicant can be enrolled at the time of hire or after a waiting period established by the group.
- ☐ The subscriber or dependent elects COBRA coverage. (Indicate if employee or dependent).

LIFE STATUS CHANGES (If multiple changes occur, use the code most applicable)
- ☐ The subscriber marries.
- ☐ The subscriber has a child, adopts, acquires, a stepchild, or becomes legal guardian of a child.
- ☐ The subscriber divorces and no longer has coverage through a spouse.
- ☐ The subscriber has a change in employment status (i.e. from part-time to full-time, hourly to salary union to non-union).
- ☐ The subscriber has a change in his/her Medicare Primary Status (employee retires and Medicare becomes primary).
- ☐ The subscriber or dependent loses coverage under another benefit plan.
- ☐ The subscriber is reinstating terminated coverage (for instance, from a leave of absence, layoff, etc.).

Other COBRA Qualifying Events
- ☐ Employer Bankruptcy (Only with respect to retirees and their Dependents)
- ☐ Employee eligible for TAA (Trade Adjustment Assistance) or ATAA (Alternative Trade Adjustment Assistance)
- ☐ USERRA (Military Deployment) (**24 Month Eligibility)**

Terminations/COBRA Qualifying Events (18 eligibility
- ☐ The subscriber is laid off ☐ Reduction of Hours (Ft to Pt.)
- ☐ Subscriber FMLA (Family Leave) expires
- ☐ The subscriber no longer employed ☐ Voluntary ☐ Involuntary

Terminations/COBRA Qualifying Event for Dependent (36 month eligibility)
- ☐ Subscriber is deceased
- ☐ Subscriber is Medicare Eligible
- ☐ Subscriber has change in marital status (Divorce)
- ☐ Dependent is over the age limit

Terminations/NON COBRA Qualifying Event
- ☐ Subscriber has coverage with another insurance company
- ☐ Dependent has coverage with another insurance company
- ☐ Dependent is deceased
- ☐ Gross Misconduct (not eligible for COBRA)

12. Severance, Medicare, and Disability

Is the employer paying any portion of the cobra premium: ☐ Yes ☐ No
If yes, end date of employer paid premiums:
If yes, total amount paid by employer: $ per month or ☐ 100%
Is this arrangement in addition to COBRA (consecutive) ☐, or part of COBRA (concurrent) ☐

Is the employee or any eligible dependents enrolled in Medicare? ☐ Yes ☐ No
If yes, please specify who is enrolled:
If yes, list Medicare Entitlement Date:

Are any Qualified Beneficiaries determined to be disabled by the Social Security Administration? ☐ Yes ☐ No
If yes, please specify name:
If yes, list Date of Determination:
Participants must provide copy of SSA letter.