Orion Health
Insurance Pool

NEW HIRE/OPEN ENROLLMENT FORM

Employer: _____

SECTION A: PLAN OPTION

☐ New Hire ☐ Open Enrollment

Employees and any Dependents must ALL elect the same Plan Option.

Check the Plan Option Desired: Medical/Rx/Dental 3 options - ☐ Core Plan ☐ 1500/3000 HDHP w/HSA* ☐ 3000/6000 HDHP w/HSA* ☐ Opt Out (Medicare/Military) life only

*Additional enrollment materials will need to be completed. There are FSA limitations if selecting this plan. This plan option is not credible for Medicare. See your employer for details.

SECTION B: MEMBERSHIP INFORMATION

Employee Last Name	First Name	Middle Initial	Vision VSP	Vision Avesis	Dental	Medical
Mailing Address		Social Security #	☐	☐	X	X
City	State	Zip				
Gender ☐ Male ☐ Female	Date of Birth (Month/Day/Year)	Daytime Phone Number	Marital Status ☐ S ☐ D ☐ W ☐ M			

SECTION C: DEPENDENT INFORMATION

Add	Last Name (if different), First, M.I.	Social Security Number	Relationship to Member	Gender	Date of Birth	Vision	Dental	Medical
☐	(Spouse/Domestic Partner)			☐ Male ☐ Female		☐	☐	☐
☐	(Child)*			☐ Male ☐ Female		☐	☐	☐
☐	(Child)*			☐ Male ☐ Female		☐	☐	☐
☐	(Child)*			☐ Male ☐ Female		☐	☐	☐
☐	(Child)*			☐ Male ☐ Female		☐	☐	☐

*Dependents age 26 or older are not eligible to be enrolled for benefits unless disabled.

SECTION F: BENEFICIARY INFORMATION (FOR LIFE INSURANCE BENEFITS)

Beneficiary Designation (Full Name)	Relationship to Member	SSN	Percentage
Mailing Address	City	State	Zip
Contingent Beneficiary Designation (Full Name)	Relationship to Member	SSN	Percentage
Mailing Address	City	State	Zip

READ CAREFULLY:

The group health care benefits available through my employer have been explained to me. I hereby apply for the benefits to which I am entitled and which I have elected on this form. I have reviewed the form to be sure that I have completed all information correctly.

- If I have declined coverage for a family member/dependent I understand that this person(s) cannot be enrolled in the Plan unless they are eligible at the next Open Enrollment period or unless there is a qualified special enrollment or a mid-year change of status event.
- I understand that benefits under this Plan re pre-tax unless a separate waiver is signed stating otherwise. I authorize the deduction of health care premium payments from my before-tax pay that will be applied to the cost of the coverages elected. I understand that the cost of coverage may be changed annually or as announced by my employer.
- I understand that the benefits elected must remain in force for the entire Plan Year and that I may not make a change in my coverage or contribution during that Plan Year, unless there is a qualified change in status as defined under the Plan in accordance with Internal Revenue Code regulations.
- I understand that premiums for domestic partner and the children of domestic partner do not qualify for pre-tax deductions under section 125 of the IRS Tax Code. I understand the deduction for medical, dental and vision premiums will be taken after tax from by pay check. I understand that the cost of coverage may be changed annually or as announced by my employer.

Authorization to Release Information: For claim purposes, I give my permission to: any physician or medical practitioner , hospital, clinic, pharmacy, insurance company, reinsurer or any other drug organization to give my employer and The Health Insurance Pool all information on my behalf including findings on medical care, alcohol or drug abuse information, psychiatric care or examination, or surgery, as they apply to me or my dependents who are covered. I know that I have the right to a copy of this authorization. A photocopy will be valid as the original.

I acknowledge by signing this form that all the information provided is true and correct to the best of my knowledge. Misrepresentation of information can result in any of the following: termination of employment, termination of coverage, criminal and/or civil prosecution. I have read the above statements and understand that if I have further benefits questions I should contact my employer's Benefits Office.

Employee Signature: _____

SECTION G: FOR HR USE ONLY – DO NOT WRITE BELOW THIS LINE

Date of Hire: _____ **Salary:** _____ **Coverage Effective Date:** _____

Employer Signature: _____ **Date:** _____