# State Employee Health Plan (SEHP) Direct Bill Group Health Insurance Enrollment and Change Form

Please Print Clearly and Complete Entire Form

| Member ID # | |
|---|---|
| Insurance Provider (Carriers Listed Below) | |
| Effective Date | |

| Name (Last, First, MI) | Date of Birth Month/Day/Year | Mailing Address ❑ Current ❑ Change |
|---|---|---|
| SSN of Member | Gender Male ❑ Female ❑ | Street Address<br>City, State Zip — County |

| Home Telephone | Spouse/Dependent of Deceased State Member ❑Yes ❑No | ID # of Deceased Member | Name of Deceased Member | Date of Death Month/Day/Year |
|---|---|---|---|---|
| | | | | |

## Type Of Action

- ❑ Add spouse and/or child(ren)
- ❑ Drop spouse and/or child(ren)
- ❑ Termination
- ❑ Split Enrollment
- ❑ Enroll in Vision coverage only
- ❑ Changing Carrier
- ❑ Drop state drug coverage
- ❑ Drop state dental coverage*
- ❑ Drop dependent dental coverage
- ❑ Medicare eligible

**Plans A or B Only - Tobacco Use -** Do you use any form of tobacco? ❑ Yes** ❑ No ❑ Choose not to disclose *Please see Non Tobacco use information on back of this form.*

**If you answered yes, are you willing to enroll in the HealthQuest tobacco cessation program? ❑ Yes ❑ No

## Health Plan Election (Please select your health plan by checking the box beside your choice)

| 2010 Medicare Plans | 2010 Medical Health Plans |
|---|---|
| ❑ Coventry Advantra Freedom PPO **with** Coventry Part D | ❑ Blue Cross & Blue Shield Plan A |
| ❑ Coventry Advantra Freedom PPO **with** SilverScript | ❑ Blue Cross & Blue Shield Plan B |
| ❑ Humana PPO **with** Humana Part D | ❑ Coventry Plan A |
| ❑ Humana PPO **with** SilverScript | ❑ Coventry Plan B |
| ❑ Kansas Senior Plan C **with** SilverScript | ❑ Preferred Health Systems Plan A |
| ❑ Kansas Senior Plan C **without** SilverScript | ❑ Preferred Health Systems Plan B |
| | ❑ UMR, A UnitedHealthCare Company Plan A |
| | ❑ UMR, A UnitedHealthCare Company Plan B |

**Vision**

- ❑ Basic
- ❑ Enhanced
- ❑ Waive coverage

**Dependent Dental Coverage**

- ❑ Yes
- ❑ No
- ❑ Opt out of Dental*

*Once a member opts out of dental coverage, they **cannot** re-enroll in dental coverage at a later date.

## Medical, Prescription Drug, Vision and Dental Coverage Level (Check one box each)

Please Note: If you are adding dependents to your coverage, **please provide documentation** such as marriage license or birth certificate

| Medical | Drug (Optional) | Vision (Optional) | Coverage Level |
|---|---|---|---|
| ❑ | ❑ | ❑ | 1 Member only |
| ❑ | ❑ | ❑ | 2 Member and Spouse |
| ❑ | ❑ | ❑ | 3 Member and Child(ren) |
| ❑ | ❑ | ❑ | 4 Member, Spouse and Child(ren) |
| ❑ | ❑ | ❑ | B Medicare Member Only |

## Dependent Information (List spouse and/or unmarried dependent children to be covered – subject to definition and Relationship codes on reverse)

| Relationship Code (See back of form) | Name (Last, First, MI) | Social Security Number (Required) | Gender M | Gender F | Date of Birth Month / Day / Year |
|---|---|---|---|---|---|
| | | | ❑ | ❑ | |
| | | | ❑ | ❑ | |
| | | | ❑ | ❑ | |

## Medicare (If you, your spouse and/or dependent is eligible for Medicare and are to be covered under the SEHP, please complete the following information and attach copies of all Medicare cards as they are REQUIRED.)

| Name (Last, First, MI) | Hospital (Part A) (Mo/Day/Yr) | Medical (Part B) (Mo/Day/Yr) | Medicare Claim Number |
|---|---|---|---|
| | | | |
| | | | |

**Member Authorization:** By my signature below, I agree to the Terms and Conditions as listed on the reverse of this form. I also understand that I must provide supporting documentation regarding any change in family status along with this enrollment form in order for my form to be processed.

Signed: ______________________________ Date:__________

Member Signature – Do Not Print

Rev. 08/09

# AUTHORIZATION: TERMS AND CONDITIONS

**Non Tobacco User Discount**

1. **I am a Tobacco User**
   - **a.** I agree to allow the State of Kansas Health Care Commission and/or Kansas Health Policy Authority to enroll me in a cessation program that I will complete, to their satisfaction, prior to the end of the 2010 plan year as a condition to obtaining the discount.

   By making this election I affirmatively declare that I am a tobacco user. However, prior to the end of the 2010 plan year, I will complete the tobacco cessation program in which I shall be enrolled by the State of Kansas Health Care Commission and/or Kansas Health Policy Authority. As a direct result of my agreement to complete this cessation program, I will receive the non-tobacco user discount for the 2010 plan year.

   - **b.** I will not enroll in or complete a cessation program and understand that I will not get the discount.

   By making this election I affirmatively declare that I am a tobacco user and choose not to participate in the non-tobacco user discount for the 2010 plan year.

2. **I am not a Tobacco User**
   - **a.** By making this election I affirmatively declare that I will not use tobacco, in any form, during the 2010 plan year. I understand that even a single instance of tobacco use may constitute a fraudulent misrepresentation on my part and may subject me to penalties.

3. **I choose not to disclose my status**
   - **a.** I choose not to disclose my status as it relates to tobacco use. I understand that by not making an election I am choosing not to participate in the non-tobacco user discount for the 2010 plan year. No negative inferences shall be made based on my decision not to disclose my status.

**I acknowledge that if I do not make a Tobacco Use election and do not return this form, I will automatically be defaulted to the base rate and will not be able to participate in the non tobacco user discount for the 2010 plan year.**

**Coverage Level Codes:**
1 = Member Only
2 = Member and Spouse Only
3 = Member and Child(ren) Only
4 = Member and Family (Spouse AND Child(ren)
B = Medicare Member Only

**Relationship Codes:**
**SP** = spouse
**D** = daughter
**P** = stepson or stepdaughter
**S** = son
**GC** = grandson or granddaughter
**L** = legal custody dependent
**XX** = qualified medical child support order
**H** = handicapped child over age 23

• I have read and agree to the provisions in the "**State of Kansas Direct Bill Open Enrollment Booklet**" for the plan year in which I am enrolling.

• I am responsible for reviewing my benefit selections for coverage on my confirmation statement. If there is an error on my confirmation statement, I must contact the Direct Bill Membership Services Department within 14 working days in order to make any corrections. If I fail to take this action timely, I waive my right to correct my election for the remainder of the current plan year.

• I verify the information on the Enrollment Form to be complete and accurate to the best of my knowledge. I understand that my answers to the questions contained on this Enrollment Form will be used to determine eligibility for coverage. I further understand that if any material information is omitted or incorrect, it could provide the basis to refuse or rescind coverage and to refund any premiums paid as though coverage had never been in force.

• If enrolling my dependent(s) for coverage, I certify that they meet the requirements for dependent coverage. Any attempt by me to enroll dependents which do not meet the requirements will be considered fraud and will be subject to penalties as prescribed by law. **I must provide appropriate proof of dependency for each dependent such as marriage license or birth certificate, along with the Enrollment or Change Form.**

• I agree to the following terms for myself and my dependents: Unless otherwise prevented by law, we authorize health care providers, insurers, claims administrators and employers to provide medical, employment and benefit information, including information relating to drug, alcohol or psychiatric histories and treatment, to the insurance provider or its authorized representatives. Except as otherwise prevented by law, the insurance provider or its authorized representatives may share such information and provide it to the employer, other insurers, claims administrators, re-insurers and other provider organizations only for the purpose of administering the group coverage and claims for benefits, utilization review, risk management, provider peer review and the resolution of grievances relating to health benefit coverage and care. This authorization shall be valid for the duration of coverage.

• I acknowledge that I have obtained a copy of this authorization.

• I agree that a reproduced copy of this authorization will be as valid as the original.