



Enrollment Application/Change Form

P.O. Box 710, Buffalo, NY 14231-0710 independenthealth.com

COMM000001

Benefit Administrator Initials	<input type="text"/>
Today's Date	<input type="text"/>
MM / DD / YYYY	

1. Employer Information/Plan Selection – Employer Information to be completed by Group Benefits Administrator

Group Individual/Conversion HRA FSA Parking/Transit

Group #	Subgroup #	Plan Number	Effective Date
<input type="text"/>	<input type="text"/>	<input type="text"/>	MM / DD / YYYY

Employer Name

Chamber or Association Name (if applicable)

2. Reason for Request/Qualifying Event

Add: Adoption Involuntary Loss of Coverage Newborn Open Enrollment
 Change in Employment Status Legal Guardianship New Hire Relocation
 COBRA (indicate reason below) Marriage/Domestic Partner New Student

Date of Qualifying Event (i.e., date of hire, date of marriage, date of placement): MM / DD / YYYY

Change: Address/Phone Number Employee Status (complete status below) Last Name

Cancel Coverage: Subscriber Dependent (indicate name below – use space in Dependent Section for additional dependent names)

Dependent Last Name	Dependent First Name
<input type="text"/>	<input type="text"/>

Which coverage are you canceling? (check all that apply) Medical FSA HRA Parking/Transit

Reason for Cancellation:

Deceased Layoff No Longer Eligible Personal Reasons
 Dependent Age Employee Cancel Nonpayment Retired
 Dissatisfaction Moved Out of Area Now Under Spouse's Plan Terminated Employment
 Transferring to Another Group

3. Employee Status Information

Employee Status/Change in Status Status Effective Date **Indicate reason for COBRA:** Left Employer Retirement
 Active COBRA Retired Inactive MM / DD / YYYY Death of Spouse Divorce/Legal Separation Reduction in Hours
 Dependent Reached Max Age Loss of Student Status

4. Employee Information - Provide information as it appears on your Social Security Card

Employee Last Name	Employee First Name	M.I.
<input type="text"/>	<input type="text"/>	<input type="text"/>

Address	Apt./Suite	Primary Language (if other than English)
<input type="text"/>	<input type="text"/>	<input type="text"/>

City	State	Zip Code	<input type="radio"/> Male <input type="radio"/> Female
<input type="text"/>	<input type="text"/>	<input type="text"/>	

E-mail Address

Social Security # (required)	Date of Birth	Primary Telephone (include area code)
<input type="text"/>	MM / DD / YYYY	(<input type="text"/>) <input type="text"/>

Home Work Cell

5. Employee Prior Health Insurance — List 12 months of cumulative coverage immediately before this application for coverage, including pertinent dates of prior coverage

Insurance Carrier Name	From (Date)	To (Date)
<input type="text"/>	MM / DD / YYYY	MM / DD / YYYY

Insurance Carrier Name	From (Date)	To (Date)
<input type="text"/>	MM / DD / YYYY	MM / DD / YYYY

Was prior coverage: single or family coverage?

6. Employee Other Health Insurance: Indicate if you will have other health insurance while enrolled with Independent Health

Insurance Carrier Name Policy Number Policy Effective Date

Policy Holder Last Name First Name

Medicare – Please indicate reason for Medicare eligibility if applicable
 Age 65+ Disability End Stage Renal Disease **Are you currently covered by Medicare Part A or Part B?** Yes No
 Medicare # (HICN) Part A Effective Date Part B Effective Date

7. Provider Selection – Provide physician information from Independent Health’s directory

Primary Care Physician # Last Name First Name

City State

OB/GYN # Last Name First Name

City State

8. Dependent #1 Information – Provide all information as it appears on dependent’s Social Security Card

Dependent Last Name Dependent First Name M.I.

Social Security # (required) - - Date of Birth Male Female

Relationship to Employee Spouse Child Other (i.e., adoption, grandchild, legal guardian, etc.)
Legal documentation may be required

If dependent is disabled and over the age of 26, please call (716) 631-8701 or 1-800-501-3439 to request a Dependent Disability Waiver.

Dependent Other Health Insurance/Medicare – Indicate if dependent will have other health insurance while enrolled

Insurance Name Policy Number Policy Effective Date

Policy Holder Last Name First Name

Medicare – Please indicate reason for Medicare eligibility if applicable
 Age 65+ Disability End Stage Renal Disease **Are they covered by Medicare Part A or Part B?** Yes No
 Medicare # (HICN) Part A Effective Date Part B Effective Date

Dependent Physician Selection – Provide physician information from Independent Health’s directory

Primary Care Physician # Last Name First Name

City State

OB/GYN # Last Name First Name

City State



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Reimbursement Account Election Form

Social Security # (required)

Grid for Social Security number

FSA HRA Parking/Transit checkboxes

Employer Name

Grid for Employer Name

Employee Last Name

Employee First Name

M.I.

Grids for Employee Last Name, First Name, and M.I.

Account Selection

Employees complete this section - Contact Group Benefits Administrator for available accounts

Table with 3 columns: Flexible Spending Account Selection, Per Pay Deduction Amount, Annual Election Amount. Rows include Premium Deduction, Unreimbursed Medical, Dependent Care*, Individual Premium, Adoption Assistance, Limited Purpose FSA.

Table with 3 columns: Parking/Transit Account Selection, Per Pay Deduction Amount, Monthly Election Amount. Rows include Parking, Transit.

Employers complete this section: (Plans with Employer Funding)

Table with 3 columns: HRA/Employer Contributions, Contribution Amount, Contribution Frequency. Rows include Unreimbursed Medical Contribution, Health Reimbursement Arrangement (1), Health Reimbursement Arrangement (2), Other.

Dependent Care guidelines as determined by Section 129 of the IRS should be reviewed carefully prior to enrollment.

I certify that I elect to participate in the reimbursement account(s) specified above for the amount(s) stated. I understand this will lower my gross pay, and consequently, my tax base and my Social Security base and the election amounts will be payroll deducted in equal installments over the course of my plan year.

By signature and date of this form, I acknowledge that my use of this plan may require submission of adequate election, claim and debit card swipe documentation. Failure to meet the requirements of the plan may result in termination of the benefit and/or repayment of reimbursed amounts.

X Employee Signature _____ Date: ____/____/____

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Grid for last 4 digits of Employee Social Security number