Employee Enrollment/Change From

Employer Name:

Effective Date: ____/____/_____ New Enrollee: ☐ Enrollment Changes: ☐

Date of Hire/Reinstated: ____/____/_____ | COBRA Yes ☐ No ☐ Variable Hour Employee? Yes ☐ No ☐ | Hours Worked Per Week:

Are you waiving your employer's group coverage? Yes, ☐ I hereby waive my employers medical coverage. Complete Step 2 below, then sign and date form.

Reason for Waiver: Individual exchange plan ☐ Individual off-exchange plan ☐ Another Employer Group Plan ☐ Medicare/Medicaid ☐ Other Coverage ☐ Not Covered ☐

STEP 1: ENROLLMENT EVENTS/CHANGES

Open Enrollment? No ☐ Yes ☐ (if Yes, then skip to Step 2) Special Enrollment Event? No ☐ Yes ☐, date: ____/____/____

Adding a Dependent? No ☐ Yes ☐ Marriage ☐ Birth, Adoption, Placement for Adoption or Foster Care ☐ Court Order ☐ Loss of other coverage ☐ Other: ___________________________

Termination of policy ☐ OR Termination of dependent ☐ Name:_________________________ Termination Date:____/____/_____ Reason: Terminated ☐ Divorce ☐ Death ☐ Other: ___________________

STEP 2: EMPLOYEE INFORMATION

Last Name:	First Name:	MI:	Social Security Number (SSN):	DOB: ____/ _____/ _____ MM/ DD / YYYY

Home Address:	Apt./Ste:	City:	State:	ZIP:
Mailing Address (if different then above):	Apt./Ste:	City:	State:	ZIP:

Primary Phone: ☐Cell ☐Work ☐Home ( )	Other Phone Number: ☐Cell ☐Work ☐Home ( )	E-mail Address:	Gender/Sex: M ☐ F ☐

Ethnicity/Race: American Indian/Alaskan Native ☐ Asian or Pacific Islander ☐ Black or African American ☐ Hispanic ☐ White ☐ Multiracial ☐

Do you or any of your dependents prefer a spoken or written language other than English? Yes ☐ No ☐
If yes, please list here:

STEP 3: PLAN INFORMATION

Your selection will be limited to the benefit plans made available to you by your employer. Any benefit discrepancies will de fault to the benefit plan offering selected by your employer. Please review the information in your enrollment materials or check with your benefits coordinator if you are uncertain about the types of benefit plans available to you. Your coverage election will be the health benefit selection made by your employer.

If your employer offers multiple Medical plans, select your coverage: HMO ☐ or PPO ☐ Medical Plan Name:	If your employer offers multiple Dental plans, select your coverage: HMO ☐ or PPO ☐ Dental Plan Name:

STEP 4: DEPENDENT INFORMATION

	Last Name	First Name	M.I.	SSN	Date of Birth	Gender/Sex
Legal Spouse/Domestic Partner						M ☐ F ☐
Child						M ☐ F ☐
Child						M ☐ F ☐
Child						M ☐ F ☐
Child						M ☐ F ☐
Child						M ☐ F ☐

STEP 5: SIGN AND DATE

I'm signing this application under penalty of perjury, which means I've provided true answers to all of the questions to the best of my knowledge. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information. I know that my information on this form will only be used to determine eligibilty for health coverage and will be kept private as required by law. If I'm eligible, it will be used to help me enroll. I know that I must tell the Small Business if anything changes (and if different than) what I wrote on this application. I hereby authorize my employer to deduct from my paycheck any required contribution for group benefits for which I am eligible. I can call my employer or broker, visit shop.nmhix.com/hix/account/user/login to report changes.

Employee Signature	Date	Employer Signature	Date

Enrollment Instructions

Please complete all of the applicable sections of the Employee Enrollment/ Change form. Sign and date the form and return form to your employer's benefit administrator or broker. Your answers on this form will only be used to see if you qualify for health coverage in the beWellnm Small Business and to help you enroll.