The Confederated Tribes of the
Warm Springs Reservation of Oregon

HealthComp
Third Party Administrators

GROUP ENROLLMENT/CHANGE FORM

P.O. BOX 45018, FRESNO, CA 93718-5018
(800) 442-7247 FAX (559) 499-2464

- ☐ New Enrollment
- ☐ Name/Address Change
- ☐ Reinstatement
- ☐ Rehire
- ☐ Annual Enrollment
- ☐ Change Enrollment
- ☐ Decline Coverage
- ☐ Termination

(Shaded area for office use only)

PART 1 EMPLOYEE INFORMATION

Confederated Tribes of Warm Springs	GROUP NUMBER **H35**	**Tribal Affiliation:** ☐Tribe Member ☐Married into the Tribe ☐Other Indian ☐Non-Indian Contract Health Eligible: ☐Yes ☐No

EMPLOYEE	LAST	FIRST	MI	SS#	EFFECTIVE DATE
MAILING ADDRESS	STREET	CITY	STATE	ZIP CODE	HOME PHONE ( )
BIRTHDATE	MO	DAY	YEAR		
HIRE DATE	JOB TITLE	☐MALE ☐FEMALE	☐SINGLE ☐MARRIED	☐WIDOWED ☐DIVORCED	☐SEPARATED
DEPARTMENT					
EMPLOYEE TERMINATION DATE	REASON				Department Code

PART 2 DEPENDENT INFORMATION

DEPENDENT INFORMATION (List persons to be covered/terminated.): [1] **Relationship Code (relationship to participant) SPO**=Spouse **SON**=Son **DAU**=Daughter **DEP**=Other Dependent

Add/ Drop	Last Name	First Name	MI	**Social Security Number **MANDATORY FOR SPOUSE ENROLLMENT**	Birth Date	Gender (Circle)	Relationship	**Tribal Affiliation**	Contract Health Eligible	Disabled
A D						M F		☐Tribe Member ☐Married into the Tribe ☐Other Indian ☐Non-Indian	Y N	Y N
A D						M F		☐Tribe Member ☐Married into the Tribe ☐Other Indian ☐Non-Indian	Y N	Y N
A D						M F		☐Tribe Member ☐Married into the Tribe ☐Other Indian ☐Non-Indian	Y N	Y N
A D						M F		☐Tribe Member ☐Married into the Tribe ☐Other Indian ☐Non-Indian	Y N	Y N
A D						M F		☐Tribe Member ☐Married into the Tribe ☐Other Indian ☐Non-Indian	Y N	Y N

IF ADDING OR DROPPING DEPENDANT STATE REASON:

PART 3 OTHER INSURANCE INFORMATION

ARE YOU OR ANY OF YOUR DEPENDENTS (INCLUDING SPOUSE) COVERED UNDER ANOTHER HEALTH PLAN OR MEDICARE? ☐**YES** ☐**NO** **IF YES, PLEASE COMPLETE THIS SECTION.** **Check if additional form attached.** ☐

Name of other policy holder	Birth Date	Social Security Number	[3] Rel. Code	Sponsoring Employer	Insurance Carrier or Medicare	Group Number	[4] Benefit Types	[5] Policy Types	Coverage Date(s)
									Begin / / End / /

PERSONS COVERED UNDER ABOVE POLICY:

3 **Relationship Code** (specify relation to participant): SPO=Spouse OTH=Other | 4 **Benefit Type(s)**: **M**=Medical **D**=Dental **V**=Vision **Rx**=Prescription | 5 **Policy Type**(s): **IND**=Individual Policy **GRP**=Group Plan **HMO**=Health Maintenance Organization **MED**=Medicare

PART 4 COVERAGE DECLINATION

To be completed if any coverage is declined or refused by an eligible employee and / or their eligible family members;

HEALTH PLAN COVERAGE (CHECK IF DECLINED)

I decline coverage for:

☐ Myself ☐ Children
☐ Spouse ☐ Spouse and Children

REASON FOR DECLINING HEALTH COVERAGE (CHECK IF DECLINED)

☐ Covered by spouse's group coverage ☐ Medicare
☐ Spouse covered by employer's group medical coverage ☐ Other (explain) ____________________

I acknowledge that the available coverages have been explained to me by my employer, and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any, and understand that evidence of insurability may be required should I choose to apply for coverage at a later date. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage.

____________________________________ ______________

If declining coverage for employee/dependent(s) please sign here. Date

PART 5 DECLARATION

☐ I hereby request the amount of coverage for which I may become eligible under the group employee benefits plan of my employer and authorized payroll deductions from my earnings (if any) required to cover my share of the premium. I confirm the above beneficiary information.

____________________________________ ______________

Employee's Signature Date