2025 Employee Enrollment/Change Form

PLEASE USE BLACK OR BLUE INK ONLY

Mail Stop 100, PO Box 1121
Lewiston, ME 04243
Fax: (207) 402-3745

Instructions: Complete this form to elect or decline your healthcare coverage with Community Health Options. If you are electing coverage, complete all sections of the form, except for section 3. If you are declining coverage, complete section 3 only. Please submit this form to your Human Resources Department.

1. EMPLOYER INFORMATION

Must be completed for both enrollment and waiver

Employer Name	Employer Address	Group # (if known)

2. EMPLOYEE INFORMATION

Must be completed for both Enrollment and Waiver

Name (Last/First/Middle Initial)			Gender M / F	Race O American Indian or Alaska Native O Asian O Black or African American O Native Hawaiian or Pacific Islander O White
Date of Hire	Date of Birth	Social Security Number	Ethnicity O Hispanic or Latino O Not Hispanic or Latino	
Will this person have other coverage while this policy is in effect? Y / N Name of Other Coverage: Certificate or Policy #:				Employee Class
Physical Address				Apt./Suite #
City	State			ZIP Code
Mailing Address (if different from physical address)				Mailing Apt./Suite #
Mailing City	Mailing State			Mailing ZIP Code
Email address				Phone ( ) - O Home O Mobile O Work

3. DECLINATION/WAIVER OF COVERAGE

To be completed if medical coverage is declined or refused by an eligible employee

Medical Coverage Declined for (select all that apply):	**Reason for declining coverage:**	
O Myself O Spouse/Domestic Partner O Dependents	O Spouse/Domestic Partner Group coverage O Medicare O Medicaid O Individual coverage O Parental Group coverage	O Retiree coverage O COBRA coverage O TRICARE Military coverage O Do not want coverage (I understand that I may face a tax penalty imposed by the IRS for not having health insurance.) O Other (please specify): _____

I acknowledge I have been given the right to apply for this coverage; however, I am electing not to enroll. By declining this coverage, I acknowledge that I and/or my dependents may have to wait until the plan's next anniversary date to be enrolled for group coverage.

Please sign here ONLY IF YOU ARE DECLINING coverage for yourself or dependent(s).

Employee Signature_____ Date_____/_____/_____

COMMUNITY Health Options

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4. ENROLLMENT INFORMATION

Must be completed if employee is electing coverage

Enrollment reason	Special Event (Required for Life Event)	Coverage Change (Required for Life Event)
O Open Enrollment – New Enrollment	O Birth or adoption	O Cancel Coverage
O Open Enrollment – Renewal	O Court Order	O Add Spouse/Domestic Partner
O New Hire	O Marriage	O Remove Spouse/Domestic Partner
O Rehire/Reinstatement	O Divorce, separation, or annulment	O Add Dependent
O COBRA Continuation	O Death	O Remove Dependent
O Decline Coverage	O Employment or benefit eligibility status change	O Name Change
O Life Event (Complete SpecialEvent and Coverage Change Sections)	O Medicare/Medicaid eligibility event	O Address Change
Date of Event: ____/____/_____	O Losing access to other coverage	O Other Change_____
*Requested Effective Date: ____/____/_____	O Termination of Employment	
	O Other: _____	

*Coverage must begin on the first of the month and end on the last day of the month (except for birth, adoption, or death.)

5. FAMILY MEMBER INFORMATION

Must be completed for eligible family members you wish to cover, delete or change
Attach an additional sheet if more than 2 dependents will be covered

Spouse / Domestic Partner

Name (Last, First, Middle Initial)		Gender M / F	Race
Date of Birth	**Social Security Number**	Ethnicity O Hispanic or Latino O Not Hispanic or Latino	O American Indian or Alaska Native O Asian O Black or African American O Native Hawaiian or Pacific Islander O White

Will this person have other coverage while this policy is in effect? Y / N
Name of Other Coverage: Certificate or Policy #:

Dependent

Name (Last, First, Middle Initial)		Gender M / F	Race
Date of Birth	**Social Security Number**	Ethnicity O Hispanic or Latino O Not Hispanic or Latino	O American Indian or Alaska Native O Asian O Black or African American O Native Hawaiian or Pacific Islander O White

Will this person have other coverage while this policy is in effect? Y / N
Name of Other Coverage: Certificate or Policy #:

Dependent

Name (Last, First, Middle Initial)		Gender M / F	Race
Date of Birth	**Social Security Number**	Ethnicity O Hispanic or Latino O Not Hispanic or Latino	O American Indian or Alaska Native O Asian O Black or African American O Native Hawaiian or Pacific Islander O White

Will this person have other coverage while this policy is in effect? Y / N
Name of Other Coverage: Certificate or Policy #:

Children may be covered as dependents by their parents up until age 26. When a dependent turns 26, coverage may continue until the end of the month. Please submit supporting documentation If a dependent listed above is a disabled dependent age 26 or older. Spouse and domestic partner and dependent eligibility is subject to your employer's eligibility guidelines.

6. MEDICAL COVERAGE (Select one plan offered by your employer)

Must be completed if employee is taking coverage

O **Health Options Clear Choice Bronze $9200 PPO National Dental Off MP** $9,200 Individual/$18,400 Family Deductible; Includes Chronic Illness Support Program, Pediatric Dental
O **Health Options Clear Choice Bronze $9200 PPO NE** $9,200 Individual/$18,400 Family Deductible; Includes Chronic Illness Support Program
O **Health Options Clear Choice Bronze $9200 HMO NE** $9,200 Individual/$18,400 Family Deductible; Includes Chronic Illness Support Program
O **Health Options Bronze $8000 Healthy Maine HMO National Off MP** $8,000 Individual/$16,000 Family Deductible; Includes Chronic Illness Support Program, WellRight®
O **Health Options Bronze $8000 Healthy Maine HMO Tiered NE** $8,000/$9,200 Individual-$16,000/$18,400 Family Deductible; Includes Chronic Illness Support Program, WellRight®
O **Health Options Bronze $8000 Healthy Maine PPO NE** $8,000 Individual/$16,000 Family Deductible; Includes Chronic Illness Support Program, WellRight®
O **Health Options Bronze $8000 Healthy Maine HMO NE** $8,000 Individual/$16,000 Family Deductible; Includes Chronic Illness Support Program, WellRight®
O **Health Options Clear Choice Bronze $7500 PPO National Dental Off MP** $7,500 Individual/$15,000 Family Deductible; Includes Chronic Illness Support Program, Pediatric Dental
O **Health Options Clear Choice Bronze $7500 PPO NE** $7,500 Individual/$15,000 Family Deductible; Includes Chronic Illness Support Program
O **Health Options Clear Choice Bronze $7500 PPO NE Dental** $7,500 Individual/$15,000 Family Deductible; Includes Pediatric Dental, Chronic Illness Support Program
O **Health Options Clear Choice Bronze $7500 HMO Tiered NE Dental Off MP** $7,500/$9,000 Individual-$15,000/$18,000 Family Deductible; Includes Chronic Illness Support Program, Pediatric Dental
O **Health Options Clear Choice Bronze $7500 HMO Tiered NE** $7,500/$9,000 Individual-$15,000/$18,000 Family Deductible; Includes Chronic Illness Support Program
O **Health Options Clear Choice Bronze $7500 HMO NE** $7,500 Individual/$15,000 Family Deductible; Includes Chronic Illness Support Program
O **Health Options Clear Choice Bronze $7200 HSA Plus PPO National Dental Off MP** $7,200 Individual/$14,400 Family Deductible; Includes Pediatric Dental, Preventive Drug List
O **Health Options Clear Choice Bronze $7200 HSA Plus PPO NE** $7,200 Individual/$14,400 Family Deductible; Includes Preventive Drug List
O **Health Options Clear Choice Bronze $6300 HSA Plus PPO National Dental Off MP** $6,300 Individual/$12,600 Family Deductible; Includes Pediatric Dental, Preventive Drug List
O **Health Options Clear Choice Bronze $6300 HSA PPO NE** $6,300 Individual/$12,600 Family Deductible
O **Health Options Clear Choice Silver $4500 HSA HMO Tiered NE Dental Off MP** $4,500/$5,400 Individual-$9,000/$10,800 Family Deductible; Includes Pediatric Dental
O **Health Options Clear Choice Silver $4200 PPO National Dental Off MP** $4,200 Individual/$8,400 Family Deductible; Includes Chronic Illness Support Program, Pediatric Dental
O **Health Options Clear Choice Silver $4200 PPO NE** $4,200 Individual/$8,400 Family Deductible; Includes Chronic Illness Support Program
O **Health Options Clear Choice Silver $4200 HMO Tiered NE Dental Off MP** $4,200/$5,040 Individual-$8,400/$10,080 Family Deductible; Includes Chronic Illness Support Program, Pediatric Dental
O **Health Options Clear Choice Silver $4200 HMO Tiered NE** $4,200/$5,040 Individual-$8,400/$10,080 Family Deductible; Includes Chronic Illness Support Program, Pediatric Dental
O **Health Options Clear Choice Silver $4200 HMO NE** $4,200 Individual/$8,400 Family Deductible; Includes Chronic Illness Support Program
O **Health Options Silver$4000 HMO National Off MP** $4,000 Individual/$8,000 Family Deductible; Includes Chronic Illness Support Program, WellRight®
O **Health Options Clear Choice Silver $3500 HSA Plus PPO National Dental Off MP** $3,500 Individual/$7,000 Family Deductible; Includes Pediatric Dental, Preventive Drug List, WellRight®

O **Health Options Clear Choice Silver $3500 HSA PPO NE Dental Off MP** $3,500 Individual/$7,000 Family Deductible; Includes Pediatric Dental, WellRight®
O Health Options Clear Choice Silver $3500 PPO National Dental Off MP $3,500 Individual/$7,000 Family Deductible; Includes Chronic Illness Support Program, Pediatric Dental
O Health Options Clear Choice Silver $3500 PPO NE Dental Off MP $3,500 Individual/$7,000 Family Deductible; Includes Chronic Illness Support Program, Pediatric Dental
O Health Options Clear Choice Silver $3500 PPO NE Dental $3,500 Individual/$7,000 Family Deductible; Includes Chronic Illness Support Program, Pediatric Dental
O Health Options Clear Choice Silver $3500 PPO National $3,500 Individual/$7,000 Family Deductible; Includes Chronic Illness Support Program
O Health Options Clear Choice Silver $3500 PPO NE $3,500 Individual/$7,000 Family Deductible; Includes Chronic Illness Support Program
O Health Options Clear Choice Silver $3500 HMO Tiered NE Dental Off MP $3,500/$4,200 Individual-$7,000/$8,400 Family Deductible; Includes Chronic Illness Support Program, Pediatric Dental
O Health Options Clear Choice Silver $3500 HMO Tiered NE $3,500/$4,200 Individual-$7,000/$8,400 Family Deductible; Includes Chronic Illness Support Program
O Health Options Clear Choice Silver $3500 HMO NE Dental $3,500 Individual/$7,000 Family Deductible; Includes Chronic Illness Support Program, Pediatric Dental
O Health Options Clear Choice Silver $3500 HMO NE $3,500 Individual/$7,000 Family Deductible; Includes Chronic Illness Support Program
O Health Options Clear Choice Gold $2500 PPO National Dental $2,500 Individual/$5,000 Family Deductible; Includes Chronic Illness Support Program, Pediatric Dental
O Health Options Clear Choice Gold $2500 PPO NE Dental $2,500 Individual/$5,000 Family Deductible; Includes Chronic Illness Support Program, Pediatric Dental
O Health Options Clear Choice Gold $2500 PPO NE $2,500 Individual/$5,000 Family Deductible; Includes Chronic Illness Support Program
O **Health Options Clear Choice Gold $1500 PPO National Dental Off MP** $1,500 Individual/$3,000 Family Deductible; Includes Chronic Illness Support Program, Pediatric Dental, WellRight®
O **Health Options Clear Choice Gold $1500 PPO National** $1,500 Individual/$3,000 Family Deductible; Includes Chronic Illness Support Program, WellRight®
O **Health Options Clear Choice Gold $1500 PPO NE** $1,500 Individual/$3,000 Family Deductible; Includes Chronic Illness Support Program, WellRight®
O Health Options Clear Choice Platinum PPO NE $500 Individual/$1,000 Family Deductible; Includes Chronic Illness Support, WellRight®

7. LEGAL ACKNOWLEDGEMENTS AND SIGNATURE

Must be completed if employee is electing coverage

I understand that:

- I will receive notice by mail of my membership status with Community Health Options once Community Health Options has received and processed my application. Upon notification of membership, I will receive a Member ID Card, online access to the applicable Member Benefit Agreement and any other necessary documents relating to my Community Health Options membership and coverage.
- If I or any covered family member is insured by more than one health contract, coordination of benefits will apply. Coordination of benefits ensures that the total benefits received from all contracts do not exceed the actual cost of covered services.
- I am requesting coverage for myself and all dependents listed on this application. All statements and answers I have given are true and complete. I understand any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact found in this application may result in denial of benefits, rescission, or cancellation of my coverage(s). I understand all benefits are subject to the conditions stated in the Member Benefit Agreement.

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

Applicant's Signature _____ Print Name _____ Date _____ /____ /_____