Care Access Health Plan, Inc., P.O. Box 4276, Hallandale, Florida 33008

Group Enrollment and Status Change Form

PART I. EMPLOYEE INFORMATION

Employer/Group		Group Number	Effective Date
Employee Last Name	First Name		Middle Initial
Home Address			Home Phone Number
City	State	Zip	County
Occupation	Social Security Number		Business Phone Number
Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Legally Separated			

PART II. BENEFITS INFORMATION
Benefits Selected: ❑ Employee only ❑ Employee plus dependent(s)
Benefits Declined: ❑ I decline Care Access Health Plan (complete Section IV.)

PART III. PERSONS TO BE ENROLLED
You must indicate a Primary Care Physician (PCP) for yourself and each of your dependents. If you do not choose a PCP, one will be assigned to you. Please refer to your Provider Directory. **Dependent Information** (use additional paper if necessary) An eligible dependent(s) is a legally married spouse, natural and/or adopted child of the eligible employee/subscriber living in the same household residing in the service area, which has applied and been approved by the Plan for Coverage, and the required premium has been paid.

Full Name	Relation	SS # (Voluntary)	Sex (Circle)	Birth date Mo/Day/Yr	Primary Care Physician Name	PCP ID
Employee	SELF		M / F			
Spouse			M / F			
Dependent			M / F			
Dependent			M / F			

PART IV. INFORMATION ABOUT OTHER COVERAGE

a. Is Spouse Employed?	b. If yes, Spouse's Employer (Name, Address and Phone Number)	
c. Do you or your spouse have other health coverage?	d. If yes, Name, Address and Policy Number of Insurance Carrier or HMO providing coverage.	e. Are you or any of your dependents covered under your Spouse's coverage or any other Insurance including Medicare or Medicaid?
		f. If yes, provide name of Company

If you have answered yes to having other coverage, will coverage(s) be terminated if this coverage is issued? If yes, identify the coverage(s) to be terminated

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Are you waiving coverage for yourself or your dependents? ❑ Yes ❑ No

PART V. AUTHORIZATION AND CONDITIONS OF ENROLLMENT
If I have elected coverage: (1) I authorize any physician or other health care provider or facility or any other entity having any information as to me or my health or that of my dependents, to provide to Care Access Health Plan, Inc. (CAHP), and/or its contracted providers or review organizations information concerning health care advice, treatment or supplies provided my dependents and/or myself relating to coverage under this prepaid health plan. This information may be used for determining eligibility, coordinating patient care, evaluating and administering claims for benefits, satisfying other business requirements in connection with the relationship and fulfilling obligations imposed on CAHP by federal or state law. The information requested by CAHP may include information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition, including consultations after the date this authorization is signed. Any other information CAHP believes to be necessary to determine eligibility for benefits may also be requested. (2) I certify that I have read the statements on this form or that they have been read to me and that all the information was provided by me and is true and complete to the best of my knowledge. I understand that any intentional material misrepresentation or material omission contained herein may be used to reduce or deny a claim or void the coverage provided under this Plan. I further understand that no agent can modify this application, waive the answers to any questions, or suggest or complete the answers thereto. (3) Unless withdrawn in writing to CAHP and accepted by CAHP, this authorization will continue to be valid during the entire term of my enrollment in this prepaid health plan. A facsimile or photocopy of this signed authorization shall be as valid as the original.

I understand that there are pre-existing condition exclusions and waiting periods, and that my coverage and that of any of the applicants identified on the enrollment shall be subject to those exclusions and waiting periods. I also understand that for pre-existing conditions there is a 24 months length of time for those pre-existing conditions, including medications.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Eligible Employee/Person Signature ______________________________ Date ______________

PART VI. QUESTIONNAIRE ***(REQUIRED)***
Please make sure that all of the information requested below is complete, true and accurate. Any misstatements or omissions in this Questionnaire may result in rescission of your enrollment/membership and/or the voiding of your enrollment/membership to its original effective date. For purposes of answering these questions, the term applicant shall refer to and include the Eligible Employee/Person and any and all Dependents for which coverage is being made and/or will be made

<u>All questions on this form must be answered.</u>

1. In the past five (5) years have you or any applicant, been diagnosed with or received treatment for any of the following diseases or malignant disorders:
   Cancer ❑ Yes ❑ No / Lymphoma and Leukemia ❑ Yes ❑ No / Melanoma ❑ Yes ❑ No / Skin Cancer ❑ Yes ❑ No / Hepatitis B or C ❑ Yes ❑ No
2. Are you, or any applicant, expecting the birth of a child for which you, (or any applicant) may need medical care? ❑ Yes ❑ No
3. Have you, or any applicant, ever tested positive for or been diagnosed as having:
   Human Immunodeficiency Virus (HIV) ❑ Yes ❑ No / AIDS Related Complex (ARC) ❑ Yes ❑ No / Acquired Immunodeficiency Syndrome (AIDS) ❑ Yes ❑ No
   Any medical condition associated with one of the above infections ❑ Yes ❑ No
4. Have you, or any applicant listed, ever been diagnosed with, or been treated for, any form of obesity? ❑ Yes ❑ No /

Employee Signature ______________________________ Date ______________

PART VII. STATUS CHANGE FORM REQUEST (NOTE: TO BE COMPLETED BY EMPLOYER ONLY AND SIGNED BY EMPLOYEE)

Member's Name	Members Identification Number

Identify type of change and provide the additional information requested in the space provided.

ENROLLMENT: ❑ New Enrollment (Specify Hire Date) ___/___/___ ❑ Reinstatement (Specify Rehire Date) ___/___/___ ❑ Open Enrollment
CHANGES: ❑ ADD DEPENDENT ❑ Marriage (Specify Date) ___/___/___ ❑ Newborn ❑ Adoption ❑ Other (Specify) ______________
❑ ADDRESS CHANGE (indicate new address in Part I.) ❑ NAME CHANGE ❑ PCP CHANGE ❑ CANCEL ALL COVERAGE
❑ CANCEL DEPENDENT(S) ONLY (provide dependent(s) name and effective date of termination of coverage)

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Any person who knowingly and with intent to injure, defraud, or deceive any files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

EMPLOYEE SIGNATURE ______________________________ Date ______________

White: CAHP Enrollment Canary: Employee Pink: Employer / Group / Association