



MIAMI-DADE COUNTY PUBLIC SCHOOLS ENROLLMENT APPLICATION

## Care Access Health Plan

Coverage provided by Care Access is described in the Certificate of Coverage. Coverage provided by Markel Insurance Company is described in their Certificate.

**If you have any questions about the Care Access Enrollment Form, please contact us at 866-222-0105.**

**Section I- Important Instructions**

1. You, the Primary Applicant, must accurately **COMPLETE ALL QUESTIONS AND INFORMATION REQUESTED to avoid delay in processing.**
2. If you need help completing this form, please call Care Access.
3. Any fraudulent statement made will void your membership beginning two (2) years from the date membership becomes effective.

**WARNING: 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.**

**Section II- Important Information**

1. Enter the required information and select payment and billing options at the end of this Application.
2. The actual effective date will be the first of the month following approval by Care Access Health Plan.
3. Coverage is not effective until you are notified by Care Access Health Plan.

**A. TELL US WHO IS APPLYING FOR COVERAGE**

**I AM APPLYING FOR:\***

(Check all that apply)

- Self     
  Self & Spouse     
  Self, Spouse + Child(ren)/Dependent(s)  
 Dependent Only  
 I am applying for CareAccess Health Plan and Markel

**\*REQUIRED INFORMATION**



**MIAMI-DADE COUNTY PUBLIC SCHOOLS ENROLLMENT APPLICATION**

**B. EMPLOYEE PERSONAL INFORMATION**

**Last Name\***

**First Name\***

**MI\***

**Home Address\***

**City\***

**State\***

**Zip\***

**Email Address\***

**Home Phone Number\***

**Applicant's Employee Number**

**Employment Location\***

1. \*Have any applicants had an exclusion imposed, postponed, had a waiver applied or been charged an extra premium for life, disability, or health insurance or had such insurance declined or rescinded? If yes, provide applicants' names, insurance company's name and a brief explanation.

NO

YES

2. \*Have any applicants had previous coverage with any other Carrier within the last 63 days? If so, please provide name of Carrier, effective and termination date of coverage.

NO

YES

3. \*Have any applicants had previous coverage with Care Access Health Plan? If yes, provide applicant's names and effective dates of coverage.

NO

YES

**\*REQUIRED INFORMATION**



MIAMI-DADE COUNTY PUBLIC SCHOOLS ENROLLMENT APPLICATION

**C. APPLICANT INFORMATION AND PRIMARY CARE PHYSICIAN (PCP) SELECTION**

Employee ID#  Last Name\*  First Name\*  MI\*

Plan Option\*  Low  High  
 Date of Birth\*   
 Sex\*  Male  Female  
 Weight\*  lbs. Height\*  FT.  IN.

Social Security\*  \*Do you currently have a PCP?  
 Yes  No

\*If yes, please list current doctor's name, address and phone below.

Name\*  \*Phone   
 Address\*  \*Premium \$

**DEPENDENT #1**

Employee ID#  Last Name\*  First Name\*  MI\*

Plan Option\*  Low  High  
 Date of Birth\*   
 Sex\*  Male  Female  
 Weight\*  lbs. Height\*  FT.  IN.

Social Security\*  \*Do you currently have a PCP?  
 Yes  No

\*If yes, please list current doctor's name, address and phone below.

Name\*  \*Phone   
 Address\*  \*Premium \$

\*REQUIRED INFORMATION



MIAMI-DADE COUNTY PUBLIC SCHOOLS ENROLLMENT APPLICATION

**DEPENDENT #2**

Employee ID#  Last Name\*  First Name\*  MI\*

Plan Option\*  Low  High Date of Birth\*  Sex\*  Male  Female Weight\*  lbs. Height\*  FT.  IN.

Social Security\*  \*Do you currently have a PCP?  Yes  No

\*If yes, please list current doctor's name, address and phone below.

Name\*  \*Phone

Address\*  \*Premium \$

**DEPENDENT #3**

Employee ID#  Last Name\*  First Name\*  MI\*

Plan Option\*  Low  High Date of Birth\*  Sex\*  Male  Female Weight\*  lbs. Height\*  FT.  IN.

Social Security\*  \*Do you currently have a PCP?  Yes  No

\*If yes, please list current doctor's name, address and phone below.

Name\*  \*Phone

Address\*  \*Premium \$

\*REQUIRED INFORMATION



**MIAMI-DADE COUNTY PUBLIC SCHOOLS ENROLLMENT APPLICATION**

**D. CONDITIONS OF ENROLLMENT FOR CARE ACCESS HEALTH PLAN**

**GENERAL CONDITIONS\***  **Accept**

**Any intentional or unintentional non-disclosure or misstatement of fact in application materials is cause for disenrollment and rescission of the Plan Contract and Care Access may recoup any amounts paid for Covered Services obtained as a result of such non-disclosure or misstatement of fact.** In the event of disenrollment or rescission of the Member, Care Access shall have no liability for the provision of coverage under the Certificate of Coverage.

**PAYMENT OF PREMIUM\***  **Accept**

**You and/or any applicant are responsible for the first month's premium as well as any future payments for coverage and any non-payment will be subject to termination.**

**OMISSIONS CLAUSE\***  **Accept**

I represent that all statements and answers made in this document, by whomsoever written including on any attached papers, are complete, true and correct. I agree that this shall be the basis of my acceptance for membership. I realize that any misrepresentation or omission, for any reason, may result in rescission of my coverage.

**\*REQUIRED INFORMATION**



**MIAMI-DADE COUNTY PUBLIC SCHOOLS ENROLLMENT APPLICATION**

**E. APPLICANT'S CERTIFICATION**

**MINOR AS PRIMARY APPLICANT\***       **Accept**

If the Primary Applicant under this Application is under 18 years of age, the Applicant's parent or legal guardian must verify as such. In such event, the parent or legal guardian does hereby agree to be legally responsible for the for the accuracy of information in this Application and for payment of premium. If such responsible party is not the natural parent of the Applicant, copies of the court papers authorizing guardianship must be submitted with this application.

**ACKNOWLEDGEMENT AND AGREEMENT\***       **Accept**

I understand and agree that by enrolling or accepting services under the coverage provided by Care Access, I and any enrolled dependents are obligated to understand and abide by all terms, conditions and provisions of the Certificate of Coverage. I have read and understand the terms on all pages on this Application including the conditions of enrollment. I understand if this application is accepted it will become part of the Certificate of Coverage. My signature below indicates my acceptance of these terms and that the information entered in this application is complete, true and correct.

**AUTHORIZATION TO RECEIVE AND RELEASE INFORMATION\***       **Accept**

I, on my behalf and on behalf of any applying family member under the age of 18, do hereby authorize Care Access and its authorized employees, its agents, and independent contractors and Participating Providers to release to, or obtain from, any person, provider, organization or government agency, any information and records, including patient records of applicants and information on any condition, which Care Access requires or is obligated to provide pursuant to legal process, federal, state or local law, or otherwise requires to administer the health plan. I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health, to give Care Access, or its reinsurers, any such information. A photo copy of this Authorization is considered as valid as the original. You are entitled to make and return a photocopy of this authorization. This authorization shall remain in effect indefinitely unless properly terminated by written notice.

**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.**

**I have read and understand the terms included in this Application. My Signature below indicates my acceptance of these terms and that the information I have entered on this Application is complete true, and correct. Care Access reserves the right to rescind coverage due to any material misrepresentation on this Application. Material misrepresentation is determined at the sole discretion of Care Access.**

**\*Employee Applicant Signature**

**x**  
\_\_\_\_\_

**\*Minor Applicant Signature**

**x**  
\_\_\_\_\_



**MIAMI-DADE COUNTY PUBLIC SCHOOLS ENROLLMENT APPLICATION**



**F. HOSPITAL INDEMNITY & GROUP POLICY**

**MARKEL BASIC HEALTH INSURANCE (MBHI)\***  **Accept**

I elect coverage under MARKEL BASIC HEALTH INSURANCE (MBHI is a Virginia Company licensed in Florida to offer defined benefit hospital insurance). **MBHI is not part of Care Access Health Plan.**

I understand that this enrollment form is subject to acceptance by Markel Insurance Company. The statements contained herein are true and complete and together with any other forms signed by me in connection with this enrollment form, form the basis for any certificate issued hereunder. I agree that any material misrepresentations shall render the insurance voidable at the instance of the insurer. All statements and descriptions are deemed to be representations and not warranties.

**Florida Residents:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR ANY APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

**\*REQUIRED INFORMATION**



**MIAMI-DADE COUNTY PUBLIC SCHOOLS ENROLLMENT APPLICATION**

**PAYMENT AND BILLING INFORMATION**

**MONTHLY BILLING OPTIONS**  
**(\*Choose One)**

- Monthly Electronic Funds Transfer (EFT)
- Debit Card
- Credit Card

PLEASE COMPLETE THE APPROPRIATE FORM

**TOTAL PREMIUM: \$**

**\*REQUIRED INFORMATION**



**MIAMI-DADE COUNTY PUBLIC SCHOOLS ENROLLMENT APPLICATION**

**PAYMENT AND BILLING INFORMATION**

**MONTHLY BILLING OPTIONS**  
 (\*Choose One)

- Monthly Electronic Funds Transfer (EFT)
- Debit Card
- Credit Card

**ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION**  
 (Deduct Payment from checking account)

**TOTAL PREMIUM: \$**

\*Name:

\*Address:

\*City:  \*State:

\*Zip Code:

\*Telephone Number:

Fax Number:

\*Account Holder's Name:

\*Account Number:

\*Bank's Name:

\*Bank's Address:

\*Routing Number:

\*Routing Number can be found on the left-hand side of the check.  
 Please write the first 9 numbers after the colon in the box.

I hereby authorize the Plan and the bank named above to initiate entries to my checking or savings account. This authority will remain in effect until I notify Care Access in writing and Care Access receives such notice to cancel it in such time as to afford reasonable opportunity to act on it. I understand that if the necessary funds are not available in my account on the first of the month to execute the automatic entry, I will be terminated effective the last day of the month in which there are insufficient funds available following the 10-day grace period. I also understand that any changes or cancellations to my account require a 14-day written notice to Care Access. Following the grace period, I will be responsible for any medical services received after the termination date.

**\*REQUIRED INFORMATION**

MIAMI-DADE COUNTY PUBLIC SCHOOLS ENROLLMENT APPLICATION

**PAYMENT AND BILLING INFORMATION**

**MONTHLY BILLING OPTIONS**

(\*Choose One)

- Monthly Electronic Funds Transfer (EFT)
- Debit Card
- Credit Card

**CREDIT/DEBIT INSTRUCTIONS**

(Choose one and complete the corresponding information)

- American Express
- Visa
- Master Card
- Discover
- Other

**TOTAL PREMIUM: \$**

\*Name on Card:

\*Card Number:

\*Expiration Date:

\*Security Code:

I hereby authorize Care Access Health Plan to charge my Credit Card account for monthly recurring charges related to health insurance premiums or any past due balances in order to bring the account to current status. This authorization is valid until my Care Access Health Plan policy is terminated, or closed voluntarily by myself, in \*writing 10 days before my next billing due date.

Care Access Health Plan reserves the right to charge the credit card currently on record for any unpaid services or premiums for a periods not to exceed 10 days after the closure of my Care Access Health Plan policy.

**\*REQUIRED INFORMATION**