GEMCare Health Plan, Inc.

Eligible Employee Group Enrollment / Change Form
Large Group: 51 + Employees

Please print or type in black ink only. See instructions before completing this form. Retain a copy of this application for your records.

TO BE COMPLETED BY EMPLOYER (for new employee)		
Company Name / DBA		Hire Date (mm/dd/yyyy)
Group Number	Enrollment Unit	Effective Date of Enrollment or coverage effective date (mm/dd/yyyy)

TO BE COMPLETED BY EMPLOYEE (if applying)

NEW ENROLLMENT, please check one:

- ❑ New hire
- ❑ Re-hire
- ❑ Open enrollment
- ❑ New group
- ❑ Other coverage loss, Qualifying event:_____date (mm/dd/yy)_____
- ❑ COBRA

APPLYING FOR: **Check one:** **HMO Plan A** ☐ HMO **Plan B** ☐ HMO **Plan C** ☐ HMO **Plan D** ☐ Other: _____
Check one Rx Plan: **10/20/35** ☐ **10/25/40**☐ **15/30/45** ☐ **10/20** ☐

IF MAKING A CHANGE, COMPLETE THE FOLLOWING:

❑ Add Dependent (complete sections *A, B, C, and D*)

❑ Delete Dependent (complete *sections* A, *B, and D)*
Reason / Event Date (mm/dd/yyyy) :

❑ Name Change (complete *sections A and B)* *Current Name*: _____New Name: _____

❑ Address Change (complete section A) ❑ Telephone Change (complete section A)

A. EMPLOYEE (Primary Applicant)

Name (Last, First, MI):	Social Security Number:

Job Title/Class:	Gender ❑M ❑F	Birth Date (mm/dd/yyyy):	Average number of hours worked per week? FT or PT? _____	Height (ft,in):	Weight (lbs):

Home Street Address (other than P.O. Box)	City	State	Zip

Home Phone: ( ) Cell Phone: ( )	Work Phone: ( ) Best Time to Call:	E-mail Address:
Status: ❑ Single ❑ Married ❑ Divorced ❑ Widow ❑ Legally Separated	Check One: ❑ Full-Time ❑ Part-Time ❑ Retiree ❑ Seasonal ❑ Temporary ❑ Cal-COBRA* ❑ COBRA* * Start date: _____ * End date: _____	Primary Care Physician (PCP) Name: _____ PCP Provider Number: _____ Are you an Existing Patient? ☐ Yes ☐ No

Preferred spoken or written language: ❑ English ❑ Spanish ❑ Other: _____

Page 2 (cont.) Employee Name and SSN: _____

B. DEPENDENT APPLICANTS For additional Dependents, attach a separate page with Employee's Name listed.

1. ❑ Add ❑ Delete	Name (Last, First, M)_____ ❑**Spouse or** ❑ **Domestic Partner** Birth Date (mm/dd/yyyy): _____ ❑ Male ❑ Female	Date of Marriage, Divorce, or Separation:
Social Security Number:	Height (ft/ in) : _____ Weight: (lbs.): _____	Primary Care Physician (PCP) Name: _____ PCP Provider Number: _____ Is he/she an Existing Patient? ☐ Yes ☐ No

2. ❑ Add ❑ Delete	❑**Child** ❑ **Step-Child** ❑ **Adopted / Other:**	❑Different Last Name _____ ❑ Disabled: ❑ Lives at Another Address Location:_____
Child Name: (Last, First, MI)		

Social Security Number:	Gender ❑M ❑F	Birth Date (mm/dd/yyyy):	Height (ft/ in) : _____ Weight: (lbs.): _____	Primary Care Physician (PCP) Name: _____ PCP Provider Number: _____ Is he/she an Existing Patient? ☐ Yes ☐ No

3. ❑ Add ❑ Delete	❑**Child** ❑ **Step-Child** ❑ **Adopted / Other:**	❑Different Last Name ❑ Lives at another address: location _____ ❑ Disabled: _____
Child Name: (Last, First, MI)		

Social Security Number:	Gender ❑M ❑F	Birth Date (mm/dd/yyyy):	Height (ft/ in) : _____ Weight: (lbs.): _____	Primary Care Physician (PCP) Name: _____ PCP Provider Number: _____ Is he/she an Existing Patient? ☐ Yes ☐ No

4. ❑ Add ❑ Delete	❑**Child** ❑ **Step-Child** ❑ **Adopted / Other:**	❑Different Last Name ❑ Lives at another address: location _____ ❑ Disabled: _____
Child Name: (Last, First, MI)		

Social Security Number:	Gender ❑M ❑F	Birth Date (mm/dd/yyyy):	Height (ft/ in) : _____ Weight: (lbs.): _____	Primary Care Physician (PCP) Name: _____ PCP Provider Number: _____ Is he/she an Existing Patient? ☐ Yes ☐ No

5. ❑ Add ❑ Delete	❑**Child** ❑ **Step-Child** ❑ **Adopted / Other:**	❑Different Last Name ❑ Lives at another address: location _____ ❑ Disabled: _____
Child Name: (Last, First, MI)		

Social Security Number:	Gender ❑M ❑F	Birth Date (mm/dd/yyyy):	Height (ft/ in) : _____ Weight: (lbs.):	Primary Care Physician (PCP) Name: _____ PCP Provider Number: _____ Is he/she an Existing Patient? ☐ Yes ☐ No

Page 3 (cont.) Employee Name and SSN: _____

C. OTHER COVERAGE Including yourself, do any of the Applicants listed currently have other group or individual medical coverage, or COBRA? Or had prior coverage within the last 63 days? ❑ Yes ❑ No If "Yes", complete the information below for each Applicant/Dependent with other coverage and provide Proof of Coverage in the form of a Certificate of Creditable Coverage and/or Medicare ID card:

Applicant Name	Insurance Carrier Name	Group, Individual, or Medicare?	Policy Number/Effective Date	Will GEMCare replace this coverage?

D. APPLICATION Authorization, Signature, and Health Plan Arbitration Agreement:

My signature declares that the answers and information presented on this application are complete and true for all Applicants to the best of my knowledge and belief, and this information will be used as the basis for underwriting. I understand that any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act when determined by a court of competent jurisdiction, and as such may be subject to criminal and civil penalties. I understand that coverage under the plan I am applying for will not take effect until issued by GEMCare. I understand that the following parties may need to provide or collect information on me or my Dependent Applicants: GEMCare and its reinsurers, any insurance support organization, related Business Associates, any consumer reporting agency, physicians, hospitals, clinics, and all persons authorized to represent these organizations for this purpose. I authorize any health care provider, hospital or medically related facility, pharmacy, or pharmacy related facility, consumer reporting agency, insurance or reinsurance company, having information about me or any of my Dependent Applicants to provide all such information as requested by GEMCare or its Business Associates or Agents. I authorize that the following information may be disclosed to or by GEMCare: any and all individually identifiable health information, including but not limited to medical records, medical benefit histories, prescription drug benefit histories, medical reports, pharmaceutical records, diagnostic testing, and lab work results. Those parties that may need to collect information may disclose information as allowed by law to the following: other insurers to which I have applied or may apply, reinsurers, pharmacy benefit managers, physicians, hospitals, Business Associates, clinics or other medically related facilities, health care clearing houses, or persons who perform business, professional, or insurance tasks for GEMCare.

I understand that this Authorization is needed for the purpose of gathering information to make eligibility, underwriting and group rating determinations and includes any and all information regarding diagnosis, treatment, and prognosis or medical conditions including physical, mental, psychiatric, drug, alcohol, and prescription history. Unless revoked earlier, this Authorization will be valid for thirty (30) months after the date it is signed, and a photocopy of this authorization is as valid as the original. I understand that I can revoke this authorization at any time by giving written notice to GEMCare. I also understand that my revocation will not affect the rights of any individual who has acted in reliance on the Authorization prior to receiving notice of my revocation. I understand that authorizing the disclosure of this health information is voluntary, and I can refuse to sign this authorization. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this Authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

I understand that this coverage is an Employer Group Health Plan and that my Employer is required to contribute funds toward the cost of this coverage. I certify that I am an authorized representative of all Applicants, and that I have been given their authority to sign on their behalf. I understand that (except for Small Claims Court cases, claims subject to Medicare appeals procedure, or if my Group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs, or other associated parties on the one hand and GEMCare, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in a GEMCare Health Plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up my right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

Employee/Primary Applicant Signature: _____ **Date:** _____