HealthCare Solutions Group
P.O.. Box 1309 Muskogee, OK 74402 ● (918) 687-1261 ● (800) 749-1422

ENROLLMENT/CHANGE & PREMIUM CONVERSION FORM

Employer:	**Group #**	**Dept:**	**Plan:**	**Network:**
TULSA FIREFIGHTERS	M8086	☐ **Active** ☐ **Retiree**	☐ HDHP ☐ Traditional	☐ HCH ☐ First Health

Name of Employee (Last, First, MI) (Please Print)			Social Security Number
Mailing Address	City	State	Zip Code	Home Phone #

☐ Male ☐Female	Employee Birth Date / /	Date of Hire/Rehire / /	Effective Date / /

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated

COVERAGE INFORMATION

Medical Coverage Elected: ☐ Single or ☐ Family

☐Add dependents – check event and give date (List dependents below)
☐Marriage–Date: _____ ☐ Birth or ☐Adoption Date:_____
☐Remove dependents – check event and give date.
☐Divorce-Date of Decree: _____ ☐ Death-Date: _____
☐Other Ineligible – Specify: _____
☐Change Medical/Dental Coverage to: ☐ Employee Only ☐ Employee & Family

☐ Change name to that shown above. My former name was: _____
☐ Does this name change affect other covered dependents?
☐ If so, specify: _____
☐ Change address to that shown above.
☐ Change Beneficiary to that shown above.
☐ Other _____

DEPENDENT/RELATIONSHIP INFORMATION

LIST ONLY COVERED DEPENDENTS - INDICATE RELATIONSHIP OF EACH DEPENDENT

S=SPOUSE/C=COMMON LAW SPOUSE/N=NATURAL CHILD/T=STEP CHILD/F=FOSTER CHILD/G=GRAND CHILD/A=ADOPTED CHILD /O=OTHER (MUST SPECIFY)

LAST, FIRST, MI	REL CODE	Social Security Number	Birthdate Mo/day/yr	Sex M	Sex F	Spouse's Employer/Phone #
Spouse						
Child						
Child						
Child						
Child						

Do you or your dependents have other coverage? ☐YES ☐NO If yes, list who is covered? _____
Type of Coverage: _____Medical _____ Dental Name/Phone Number of carrier: _____
Is any applicant disabled/handicapped? ☐YES ☐NO (If yes, please provide documentation)

Acceptance of Coverage

I am enrolling under my employer's health benefit plan for the coverage elected above.

Signature _____ **Date** _____

Declining Coverage

If you are declining enrollment for yourself or any dependent (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within thirty- (30) days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within thirty (30) days after the marriage, birth, adoption, or placement for adoption. To qualify for the special enrollment period, the employee (or dependent) must have lost the other group health plan coverage because either COBRA is now exhausted or non-COBRA coverage terminated due to loss of eligibility for coverage (including due to legal separation, divorce, death, termination of employment, or reduction of the hours) or because employer contributions for the coverage were terminated, I understand the above statement and forfeit my right to become eligible unless I qualify under the above conditions. I waive health coverage for myself and/or dependents, if any.

If you have refused employee coverage, is it because you have other coverage? ☐ **YES** ☐ **NO**

If you have refused dependent coverage, is it because your dependents have other coverage? ☐ **YES** ☐ **NO**

Signature _____ **Date** _____