DeSoto Memorial Hospital Medical Plan Enrollment Form

DESOTO MEMORIAL HOSPITAL

SECTION 1: ENROLLMENT/CHANGE TRANSACTION TYPE

Select Enrollment/Change Transaction Type from below: | **Effective Date: 01/01/2023**

☐Annual Enrollment
☐Add/Remove Dependent ☐Change Plan Selection ☐Change Coverage Level
☐Terminate Coverage If terminating, select reason: ☐Death ☐Divorce ☐Employment Terminated ☐Retired ☐Voluntary

☐New Employee Date of Hire: _____/_____/_____

☐Update Demographics
☐Name Change ☐Address Change ☐Date of Birth Change ☐SSN change ☐Other _____

☐Life Change Event
☐Add/Remove Dependent ☐Change Plan Selection ☐Change Coverage Level
☐Terminate Coverage If terminating, select reason: ☐Death ☐Divorce ☐Employment Terminated ☐Retired ☐Voluntary

Qualifying Event: ☐Marriage/Divorce ☐Birth/Adoption ☐Court Order ☐Loss of Coverage ☐Other: _____

SECTION 2: EMPLOYEE INFORMATION

Last Name:	First Name:	MI:	Suffix:
Email:	Sex: ☐M ☐F	SSN #: _____/_____/_____	
Date of Birth: _____/_____/_____	Race:	Primary Language:	

Is employee declining coverage? ☐No ☐Yes, Reason: ☐Other Coverage ☐Other:

Residence Address:	City:	State:	Zip:
Mailing Address:	City:	State:	Zip:

Home Phone #:	Cell Phone #:	Marital Status:

Is the Employee Covered by Medicare? ☐No ☐Yes: ☐Part A ☐Part B ☐Part C ☐Part D Effective: ____/____/_____
Reason for Medicare Coverage: ☐ Entitlement Age ☐ Disability ☐End Stage Renal Disease (ESRD)

Does employee have other coverage? ☐No ☐Yes, ☐Medical ☐Prescription Plan/Carrier:
Health Plan Selection for Employee: ☐ DPC Medical (Epiphany Health) ☐ Non-DPC Medical

Flex Spending Account

☐Flexible Spending (FSA) Annual Contribution $_____ Bi-weekly deduction $_____ ☐ Elect ☐ Decline
☐Dependent Care Flexible Spending (DCFSA) Annual Contribution $ _____ Bi-weekly deduction $ _____ ☐ Elect ☐ Decline

SECTION 3: DEPENDENT INFORMATION (Use additional form for additional dependents)

Spouse	Last Name:	First Name:	MI:	Suffix:
Email:		Sex: ☐M ☐F	SSN #: _____/_____/_____	
Date of Birth: _____/_____/_____		Race:	Language:	

Will spouse be declining coverage? ☐No ☐Yes, Reason: ☐Other Coverage ☐Other:

Address: ☐same as employee	City:	State:	Zip:

Is this dependent covered by Medicare? ☐No ☐Yes: ☐Part A ☐Part B ☐Part C ☐Part D Effective: ____/____/_____
Reason for Medicare Coverage: ☐ Entitlement Age ☐ Disability ☐End Stage Renal Disease (ESRD)

Does spouse have other coverage? ☐No ☐Yes
If yes, please indicate: ☐Medical ☐Prescription Plan/Carrier:
Health Plan Selection for Spouse: ☐ DPC Medical (Epiphany Health) ☐ Non-DPC Medical

Child 1	Last Name:	First Name:	MI:	Suffix:

☐Natural/Adopted ☐Stepchild ☐Foster Child ☐Grandchild ☐Legal Guardian ☐Disabled ☐ Other:

Sex: ☐M ☐F	SSN #: _____/_____/_____	Date of Birth: _____/_____/_____

Will this child be declining coverage? ☐No ☐Yes, Reason: ☐Other Coverage ☐Other:

Address: ☐same as employee	City:	State:	Zip:

Is this dependent covered by Medicare? ☐No ☐Yes: ☐Part A ☐Part B ☐Part C ☐Part D Effective: ____/____/_____
Reason for Medicare Coverage: ☐ Entitlement Age ☐ Disability ☐End Stage Renal Disease (ESRD)

Does this child have other coverage? ☐No ☐Yes, ☐Medical ☐Prescription Plan/Carrier:
Health Plan Selection for Child 1: ☐ DPC Medical (Epiphany Health) ☐ Non-DPC Medical

Child 2	Last Name:	First Name:	MI:	Suffix:

☐Natural/Adopted ☐Stepchild ☐Foster Child ☐Grandchild ☐Legal Guardian ☐Disabled ☐ Other:

Sex: ☐M ☐F	SSN #: _____/_____/_____	Date of Birth: _____/_____/_____

Will this child be declining coverage? ☐No ☐Yes, Reason: ☐Other Coverage ☐Other:

Address: ☐same as employee	City:	State:	Zip:

Is this dependent covered by Medicare? ☐No ☐Yes: ☐Part A ☐Part B ☐Part C ☐Part D Effective: ____/____/_____
Reason for Medicare Coverage: ☐ Entitlement Age ☐ Disability ☐End Stage Renal Disease (ESRD)

Does this child have other coverage? ☐No ☐Yes, ☐Medical ☐Prescription Plan/Carrier:
Health Plan Selection for Child 2: ☐ DPC Medical (Epiphany Health) ☐ Non-DPC Medical

Child 3	Last Name:	First Name:	MI:	Suffix:

☐Natural/Adopted ☐Stepchild ☐Foster Child ☐Grandchild ☐Legal Guardian ☐Disabled ☐ Other:

Sex: ☐M ☐F	SSN #: _____/_____/_____	Date of Birth: _____/_____/_____

Will this child be declining coverage? ☐No ☐Yes, Reason: ☐Other Coverage ☐Other:

Address: ☐same as employee	City:	State:	Zip:

Is this dependent covered by Medicare? ☐No ☐Yes: ☐Part A ☐Part B ☐Part C ☐Part D Effective: ____/____/_____
Reason for Medicare Coverage: ☐ Entitlement Age ☐ Disability ☐End Stage Renal Disease (ESRD)

Does this child have other coverage? ☐No ☐Yes, ☐Medical ☐Prescription Plan/Carrier:
Health Plan Selection for Child 3: ☐ DPC Medical (Epiphany Health) ☐ Non-DPC Medical

Child 4	Last Name:	First Name:	MI:	Suffix:

☐Natural/Adopted ☐Stepchild ☐Foster Child ☐Grandchild ☐Legal Guardian ☐Disabled ☐ Other:

Sex: ☐M ☐F	SSN #: _____/_____/_____	Date of Birth: _____/_____/_____

Will this child be declining coverage? ☐No ☐Yes, Reason: ☐Other Coverage ☐Other:

Address: ☐same as employee	City:	State:	Zip:

Is this dependent covered by Medicare? ☐No ☐Yes: ☐Part A ☐Part B ☐Part C ☐Part D Effective: ____/____/_____
Reason for Medicare Coverage: ☐ Entitlement Age ☐ Disability ☐End Stage Renal Disease (ESRD)

Does this child have other coverage? ☐No ☐Yes, ☐Medical ☐Prescription Plan/Carrier:
Health Plan Selection for Child 4: ☐ DPC Medical (Epiphany Health) ☐ Non-DPC Medical

SECTION 4: COVERAGE SELECTION (Please select Plans for Coverage) – WILL UPDATE PER CLIENT

Plan Selection: ☐ DPC Medical ☐ Non-DPC Medical ☐ Combination Plan (DPC and Non-DPC) *Please verify you selected plan for each enrolled member if choosing combination

Coverage Type Selected: ☐Employee Only ☐Employee + Spouse ☐Employee + Child(ren) ☐Employee + Family

You consent and agree that your signature executed in conjunction with the submission of your enrollment form shall be legally binding and such transaction shall be considered authorized by you. Furthermore, you acknowledge that under federal law it is a crime to knowingly and willfully make a false statement in connection with the delivery or payment for health care benefits or services (18 USC SEC. 1035) or to attempt to defraud a health program or otherwise convert money from a health care fund (18 USC SEC. 669 and 18 USC SEC. 1347). These crimes are punishable by a fine or imprisonment or both. Your signature below constitutes that the information on this form is truthful and accurate to the best of your knowledge.

Applicant Signature: _____ Date: _____