FORM B

Must be completed **ONLY IF** Employee is Making Changes
Due to the County Board Office 10/28/2022

HOPE TRUST
Health Options for Public Entities

Employee Enrollment Form

EMPLOYER MUST FAX COMPLETED FORM to SRM (HOPE Trust Plan Administrator) at 309-543-6607

REASON FOR ENROLLMENT

(to be completed by Employer; check all boxes that apply)

New Enrollment: _____ New Hire/Full-Time (Date: _____) _____ Open Enrollment

Special Enrollment: _____ Dependent Spouse Addition _____ Dependent Child Addition

_____ Involuntary Loss of Coverage _____ Birth _____ Adoption

_____ Marriage _____ Other: _____

Date of Event Triggering Special Enrollment (mm/dd/yy): _____

EMPLOYEE INFORMATION

Date of Hire (Full-Time) (mm/dd/yy) _____ Social Security Number _____

Last Name _____ First Name _____ Middle Initial _____ Date of Birth (mm/dd/yy) _____

Home Address _____ City _____ State _____ ZIP _____ Male Female Gender (circle one)

Home (or Cell) Phone Number _____ Single Widowed or Divorced Married or Civil Union Marital Status (circle one)

DEPENDENTS TO BE COVERED

First Name	M.I.	Last Name (If Different)	Soc. Sec. #	Relationship (Spouse/Son/Daughter)	Date of Birth (mm/dd/yy)

PLAN OPTION SELECTION

Traditional Major Medical Plan → [ ] Self [ ] Spouse [ ] Child(ren)

QHDHP (HSA-Compatible) → [ ] Self [ ] Spouse [ ] Child(ren)

Health Reimbursement Plan (HRP) → [ ] Self [ ] Spouse [ ] Child(ren)

Dental & Vision Plan *(Optional)*
[ ] Self [ ] Spouse [ ] Child(ren)

[ ] Other; *if Other, please explain:*

NOTE: A covered employee and his/her covered dependents must generally be covered under the same plan option, with the exception of dependent election or declination of Dental & Vision coverage.

Continued on next page -->

HOPE TRUST
Health Options for Public Entities

Employee Enrollment Form (continued)

EMPLOYER MUST FAX COMPLETED FORM to SRM (HOPE Trust Plan Administrator) at 309-543-6607

INFORMATION ABOUT OTHER COVERAGE

Will you or any of your covered dependents (spouse and/or child(ren)) keep other coverage in addition to this coverage? **YES** **NO**

Are you or any of your covered dependents (spouse and/or child(ren)) covered through a **spouse's employer plan**? **YES** **NO**

Spouse's Employer	Insurance Company	Who is Covered on Spouse's Plan? (circle all that apply) Self	Spouse	Child(ren)

Are you or any of your covered dependents (spouse and/or child(ren)) covered through **Medicare**? **YES** **NO**

If Yes, Who? ___ Self ___ Spouse ___ Child(ren) If Yes, Why? ___ Age ___ Disability ___ Kidney Failure

Type of Coverage: ___ Part A ___ Part B ___ Part D

Are any of your covered dependents (spouse and/or child(ren)) totally or temporarily disabled? **YES** **NO**

If Yes, Who? _____ Date of Disability: _____

Are you or any of your covered dependents (spouse and/or child(ren)) covered through **Medicaid**? **YES** **NO**

If Yes, Who? ___ Self ___ Spouse ___ Child(ren)

Are you or any of your covered dependents (spouse and/or child(ren)) covered through **Tri-Care**? **YES** **NO**

If Yes, Who? ___ Self ___ Spouse ___ Child(ren)

MEDICAL HISTORY

Have you or any of your covered dependents (spouse and/or child(ren)) been diagnosed with or have planned future surgeries or treatments for heart disease, cancer, neck or back disorder, kidney/renal disease or failure, organ or tissue transplant, or AIDS/HIV/autoimmune disease?

YES **NO** If Yes, indicate Who, and please provide an additional explanation below *(attach additional pages, if needed)*:

ACKNOWLEDGEMENT & SIGNATURE

I understand, agree, and represent that I have read this document or it has been read to me; the answers provided within this entire Employee Enrolllment Form are, to the best of my knowledge and belief, true and complete; and if I intentionally omit or provide false information on or in relation to this Employee Enrollment Form, then this coverage may be cancelled retroactively, in which case any claim I incur may not be paid by the plan and I may face legal liability. I understand further that the information I have provided in this Employee Enrollment Form will be used by the plan and its affiliates to make decisions about eligibility, enrollment, and underwriting. Finally, I authorize any physician, nurse, hospital, dentist, other person, or firm to obtain from the plan information and copies or records pertaining to medical and prescription expenses incurred by me or my family members enrolled in the plan. A photographic copy of this Employee Enrollment Form and Acknowledgement & Signature shall be as valid as the original.

_____ Signature of Employee

_____ Date