KEY BENEFIT ADMINISTRATORS

Self-Funded Medical Plan

2023

FAULKNER COUNTY ARKANSAS

Employee Information Packet

Welcome Letter

Faulkner County is proud to offer new products to employees starting January 1, 2023. Be sure to review the entire booklet to get an overview of your new benefits.

KEY BENEFIT ADMINISTRATORS

Faulkner County Medical plan will be administered by Key Benefit Administrators (KBA). KBA's national headquarters is in Indianapolis, IN and operations are in Fort Mill, SC. KBA is one of the largest independently owned third party administrators in the country.

- The Group Number is **9624**.
- Customer Service Phone Number is **800.331.4757.**

You will be receiving a welcome packet in the mail prior to 1/1/2023 that will include:

*Your New Medical ID Card

*Information on how to access the KBA Member Portal

CERPASSRX

CerpassRx is your new pharmacy benefit manager effective January 1, 2023. For prescription drugs that require a Prior Authorization either you or your physician will need to contact Key Benefit Administrators Customer Service at 1-800-331-4757 and provide the information required to request approval.

Member Web Portal: www.cerpassrx.com/members-page
Be sure to set up your Member Portal to access information.

Also access all the below information through their convenient mobile app!

*Medication History

*Participating pharmacy locations

*Compare pharmacy copays to determine the most cost-effective options

Cigna

Precertification will be handled through Cigna. A call must be placed no less than 48 hours prior to planned hospital admission and 48 hours following an emergency admission for services requiring precertification. The toll-free number is on the back of your new medical ID card. For a complete listing of services requiring precertification please refer to your plan document.

American Health Data Institute

It's Never Too Late to Live a Healthier Lifestyle!

Your Chronic Disease Management Program

The American Health Data Institute is excited to be your chronic disease management partner!
Our program covers 27 chronic conditions like asthma, diabetes, high blood pressure, high cholesterol, and coronary artery disease, just to name a few. If you or a family member have been diagnosed with a chronic illness you are automatically enrolled in the **Health Care Navigator™** program. Our Healthcare Navigator™ Nurses and Health Coaches are here to work with you to make sure you're receiving the care you need to manage your condition and live a healthier lifestyle!

How Does the Program Work?

STEP 1 If you have a qualifying chronic condition you will receive an introductory letter inviting you to partner with one of our Health Care Navigator™ Nurses or Health Coaches.

STEP 2 Following the introductory letter, either you can contact one of the Health Care Navigator™ Nurses or Health Coaches or they will reach out to you.

STEP 3 You and the Health Care Navigator™ Nurse or Health Coach will discuss your healthcare needs and co-design a personalized service plan. The Health Care Navigator™ Nurse or Health Coach is there as your partner to help you self-manage your chronic condition.

It's Easy!

Start Now and Take Control of Your Health!

CONTACT A HEALTH COACH TODAY TO:

- Receive support in managing your chronic condition
- Access medical information about your condition
- Make sure you are following the recommended care for your illness(s)

Call 1.800.352.5071
Or email your questions to: CDM@ahdi.com

27 CHRONIC CONDITIONS & MINIMUM LEVELS OF CARE

**The services listed below are the standard laboratory and diagnostic procedures for each chronic disease.*

CHRONIC CONDITION	MINIMUM ANNUAL CARE RECOMMENDED		
ASTHMA	2 Clinical Evaluations 1 Spirometry (for patients 10 years of age or older)		
ATRIAL FIBRILLATION	1 Clinical Evaluation		
CHRONIC OBSTRUCTIVE PULMONARY DISEASE	1 Clinical Evaluation 1 Spirometry		
CHRONIC VENOUS THROMBOTIC DISEASE *previously listed as Thrombo-embolic Disease*	1 Clinical Evaluation		
COPD WITH PULMONARY HYPERTENSION/COR PULMONALE	2 Clinical Evaluations 12 months of supplemental 02 Tx		
CHRONIC KIDNEY DISEASE	1 Clinical Evaluation 1 Hgb or Hcrt	1 Serum Creatinine 1 Serum Potassium	1 Serum Calcium 1 Serum Phosphorus
CONGESTIVE HEART FAILURE	1 Clinical Evaluation	1 Serum Creatinine	1 Serum Potassium
CORONARY ARTERY DISEASE	1 Clinical Evaluation	1 LDL	
DEPRESSION	1 Clinical Evaluation		
DIABETES	2 Clinical Evaluations 2 Glycohemoglobins 1 Serum Creatinine	1 Lipid Panel IF no nephropathy Dx or ACE/ARB Rx, 1 Urine Albumin/Creatinine ratio, Total Protein	
EPILEPSY	1 Clinical Evaluation		
HUMAN IMMUNODEFICIENCY VIRUS INFECTION	2 Clinical Evaluations 2CBCs I T-Cell/CD-4 Count	2 HIV Quantifications 1 Pap Smear (for women only, 21 years of age or older)	
HYPERLIPIOEMIA	1 Lipid Panel		
HYPERTENSION	1 Clinical Evaluation	1 Serum Creatinine	
HYPERTHYROIDISM	1 Clinical Evaluation	1 TSH	1 T4
HYPOTHYROIDISM	1 Clinical Evaluation	1 TSH	
METABOLIC SYNDROME	1 Clinical Evaluation	1 Lipid Panel	1 FBS or HgbA1c
MULTIPLE SCLEROSIS	1 Clinical Evaluation		
PARKINSON'S DISEASE	1 Clinical Evaluation		
PERIPHERAL ARTERIAL DISEASE (ATHEROSCLEROSIS] *previously listed as Peripheral Vascular Disease*	1 Clinical Evaluation 1 LDL		
PRE-DIABETES	1 Clinical Evaluation	1 Lipid Panel	1 FBS or HgbA1c
POLYMYALGIA RHEUMATICA	2 Clinical Evaluation	2 ESR or CRP	1 CBC
PULMONARY HYPERTENSION (UNRELATED TO COPD)	2 Clinical Evaluation		
REGIONAL ENTERITIS (INFLAMMATORY BOWEL DISEASE)	1 Clinical Evaluation		
RHEUMATOID ARTHRITIS	1 Clinical Evaluation		
SLEEP APNEA	1 Clinical Evaluation		
ULCERATIVE COLITIS (INFLAMMATORY BOWEL DISEASE)	1 Clinical Evaluation		

RealTimeHealth
AN AMERICAN HEALTH DATA INSTITUTE PRODUCT

Superior Diabetes Management at No Cost to You

Blood Glucose Meter
Cellular-connected blood glucose monitoring system

Testing Supplies
Unlimited supplies delivered right to your door*

Real-Time Support
On-screen meter messaging and product support

RealTimeHealth Diabetes Management Program

Managing diabetes can be tough—but it doesn't have to be. The RealTimeHealth program provides you with all the tools, supplies and support you need to stay on track. RealTime Health has partnered with BioTel Care® to provide you with the BioTel Care® Connected Blood Glucose Monitoring System.

Your connected meter features:

- Easy-to-use, responsive color touchscreen
- Logs automatically sent to a secure online portal
- Personalized messages to help you make informed choices
- Summary graphs and custom testing goals

*Automatic supply refills based on actual usage

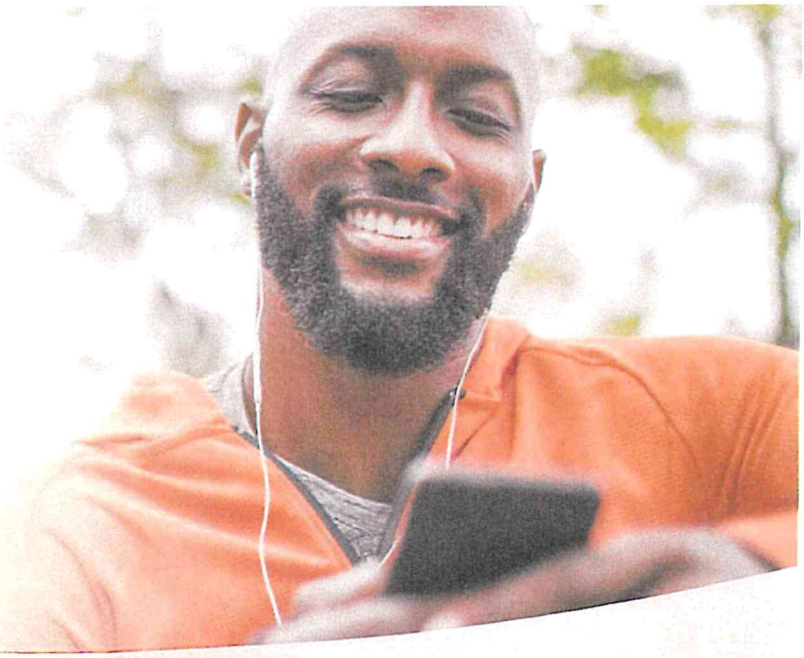
In parternship with BioTel CARE

Enroll today! Call us at 1-877-219-6628

MDLIVE

RealTime Telemed

Welcome to MDLIVE!



Using MDLIVE, you can visit with a doctor 24/7/365 from your home, office or on-the-go.

With zero co-pay!

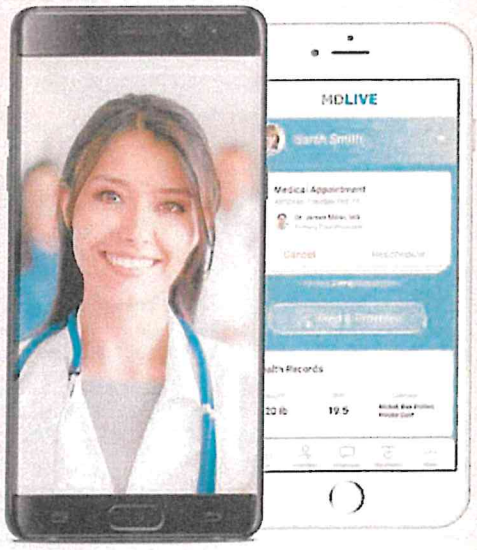
You have a telehealth benefit giving you virtual care, anywhere.

- Board-certified doctors
- Available anytime, day or night
- Consults by mobile app, video or phone
- Prescriptions can be sent to your nearest pharmacy if medically necessary

We treat over 50 routine medical conditions including:

- Acne
- Allergies
- Cold / Flu
- Constipation
- Cough
- Diarrhea
- Ear Problems
- Insect Bites
- Nausea / Vomiting
- Pink Eye
- Rash
- Respiratory Problems
- Sore Throats
- And More

Your virtual doctor is here. Join for free today!



MD **Download the app.**
Join for free. Visit a doctor.

MDLIVE.com/KBA
888.341.0698

MDLIVE

Welcome to MDLIVE! Your anytime, anywhere doctor's office.

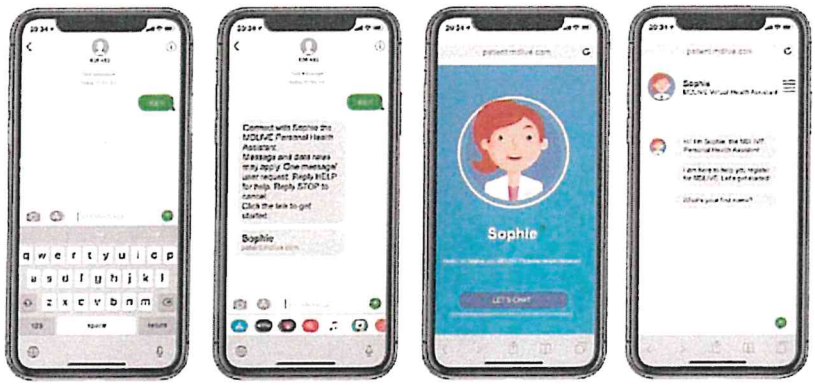
Avoid waiting rooms and the inconvenience of going to the doctor's office. Visit a doctor by phone, secure video, or MDLIVE App. Pediatricians are available 24/7, and family members are also eligible.

Meet Sophie,

Your Personal Health Assistant! Sophie makes creating an account quick and easy using your smartphone, anytime, anywhere! **It's easy to register!**

Steps To Connect to Chatbot:

1. Member will text **KBA** to 635483.
2. Tap to load preview. Member also presented with Stop/Help language.
3. Tap **"Let's Chat"** to launch a web browser page which simulates a texting conversation.



Download the app.
Join for free. Visit a doctor.

MDLIVE.com/KBA
888.341.0698

Member Portal Registration Guide

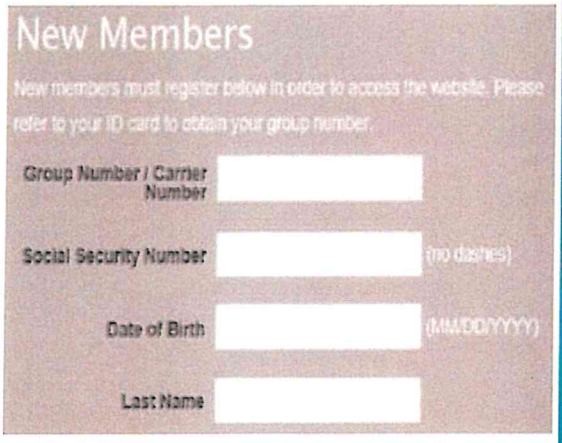
Visit **Online** or Download the **Mobile App**

Key Benefit Administrators encourages you to utilize our E-Z Benefits℠ platform for member registration. You will need the following information prior to accessing our enhanced technology: **Your group number (located on ID Card), Social Security Number, date of birth, last name and a valid email address.**

Once registered, you'll be directed to the home page with our single sign-on technology. Menu items will display options and related links customized specifically for your group benefits plan.

Online access is simple. Follow the four steps outlined below.

1. Go to the website: www.kbasolution.com. and click **Member Login** on the right hand side.
2. On the **right-hand side** of the screen, it will read **New Members**. Complete the registration questions and then click the **Signup** button. Helpful tips:
   - Enter your Social Security Number (SSN) without dashes.
   - Date of Birth must be placed in a two-digit month, two-digit day(s), and four-digit year format (i.e., 01/01/2011.)
3. Enter a **username, password,** and **valid email address.** The password must be a minimum of 6 characters long. Please make a note of your username and password.
4. You will see the **Agreement** section. Once read and understood, click the **I Agree** check box and then click **Register**.



Download the Mobile App!

The **KBA-EZ Health Guide** app is available for both Android and iPhone devices, and it's free!

Download the app and register using the four steps above.

Available features:

- View/Request ID Card
- Claim Status
- Benefit and enrollee details
- Eligibility Data
- Rx Price Comparison Tool

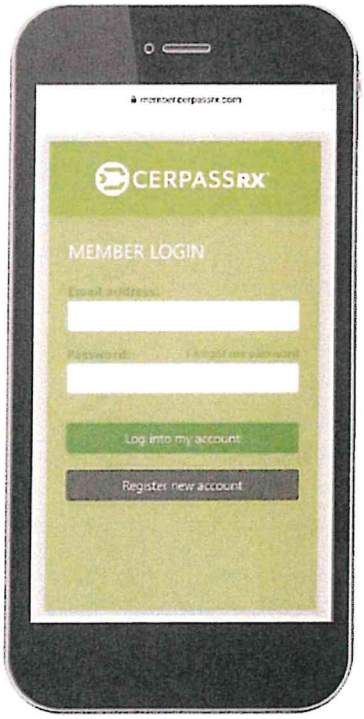
Available on the iPhone App Store | ANDROID APP ON Google play

If you have questions regarding the Member Portal, please contact Customer Service using the phone number listed on your member identification card included in this packet.

MEMBER PORTAL & MOBILE APP

This private, secure website is designed just for you. Your pharmacy plan information is available and kept up-to-date in real time. You can access your member portal by visiting www.CERPASSRX.com or by downloading our mobile app.

The mobile app provides easy, on-the-go access to your personalized health information. Once you have your member ID number, download the app to take advantage of the benefits your pharmacy plan offers.



EASY ACCESS ALLOWS YOU TO:

- Stay on top of medication refills. See when refills are due, get refill reminders and quickly contact your pharmacy.
- Pull up your medication history anytime to show your doctor what medications you are taking.
- Learn about medication side effects and interactions.
- Find network pharmacies by ZIP code or location, then check and compare current prescription prices.
- Learn ways to save on your prescription by switching from brand name to generic or splitting a higher dosage pill.
- Track individual and family spend.

Get the app by searching for CerpassRx Member Portal at the Apple App store or with Google Play.

CREATE YOUR MEMBER PORTAL ACCOUNT:

Visit cerpassrx.com and click on the member login button. Then, click "register new account" and enter your member ID shown on your ID card. From there, proceed with completing your personal information to register your member portal account.

Have questions? For more information, call or click today at 877-986-4666
www.cerpassrx.com // 5904 Stone Creek Dr, Ste. 120 The Colony, TX 75056

CERPASSRX

MAIL DELIVERY

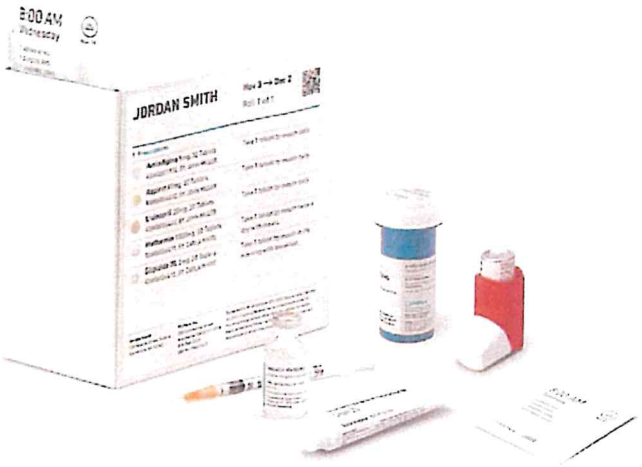
CerpassRx is proud to offer Mail Delivery by PillPack, a simple, innovative way to manage your prescription medications. PillPack, by Amazon pharmacy, is a full-service pharmacy that sorts your medication by the dose and delivers them to your door at no additional cost. We especially recommend this service if you take a medication on an ongoing basis. Here's what you need to know to use the service.

With Mail Delivery by PillPack you get...

Pre-sorted medications - If you take daily medication, PillPack can pre-sort them by date and time.

Home delivery - Get the medications you need delivered to your door every month.

No additional costs - With PillPack, service and shipping are always free. You simply pay your copays.



Payment

PillPack makes payments easy. Just add your preferred payment method and they'll charge you for your copays each time your medication ships. You can use a credit card, debit card, HSA/FSA, or a bank account. And you can update your payment information anytime through your online account.

Prescription Order Status

When your medications on its way, PillPack keeps you updated with email and text message alerts. They also provide a tracking number for every shipment. If you ever have questions, you can always call 1-855-966-0966.

PillPack Customer Service

Pharmacists are available for consultations 24 hours a day 7 days a week if you have questions about your medications, including how to take it, what to do if you miss a dose, side effects or drug interactions. For medical emergencies, please call 911.

Call PillPack at 1-855-966-0966
Monday to Friday 8am - 10pm ET
Saturday to Sunday 10am - 8pm ET
After normal business hours, a voicemail service is available for customers. Leave a message and a pharmacist will return urgent calls within 30 minutes.

Email PillPack at hello@pillpack.com
PillPack customer service teams are happy to help. However, if you have an urgent clinical need, please call 911.

Want to know more?

You can find out more information on our integrated service with PillPack by visiting **www.cerpassrx.com/pillpack**. We welcome you to watch the short video on "how it works" as well as review customer reviews.

GET STARTED

1. Grab your CerpassRx ID card, list of medications, doctor information and payment method information. You can sign up one of two ways:

Online: Visit **www.cerpassrx.com/pillpack,** click "sign up" and complete the questions to enroll.

By Phone: Call PillPack Customer Service at **1-855-966-0966**

2. During the sign up process you will have 2 options to select HOW you want to receive your medications by mail.

In bottles: If you prefer, PillPack can deliver any or all of your medication the traditional way, in bottles. Medications you take as-needed or that aren't in pill form (like inhalers, insulin, or creams) will automatically be delivered in bottles or in their original packaging.

In packets: For anything you take daily, PillPack can pre-sort your meds into packets by date and time. If you choose this option, you'll receive your first shipment about 2 weeks after signing up.
"If you are low on any medications, let PillPack know and they can send them in bottles ahead of your first shipment."

5904 Stone Creek Dr, Ste. 120 The Colony, TX 75056
844-636-7506 // www.CerpassRx.com

CERPASSRX

Pill Pack
by amazon pharmacy

KEY BENEFIT ADMINISTRATORS

Medical Coordination of Benefits Verification

Employer: Faulkner County Group # 9624

Employee Name: _____

Social Security Number/Member ID Number: _____

Address: _____

_____ _____ _____

City State Zip

Phone Number: _____

Email Address: _____

Other Health Insurance Information

Are you or any of your dependents covered under another Medical Plan? ☐ Yes ☐ No *If yes, complete the information section below.*

Name: _____ ☐ Employee ☐ Spouse ☐ Dependent Child

Name: _____ ☐ Employee ☐ Spouse ☐ Dependent Child

Name: _____ ☐ Employee ☐ Spouse ☐ Dependent Child

Name: _____ ☐ Employee ☐ Spouse ☐ Dependent Child

Policyholder Name	Policyholder's Employer Name/Address	Policyholder's Social Security #	Policy Holder Date of Birth
Name/Address of Other Insurance Company	Other Insurance Company's Phone #	Employer Phone Number	Effective Date

Employee Signature: _____ **Date** _____

Faulkner County – Menu of Benefits 2023

Employee Benefits (Deductions based on a 24 pay period cycle.)

Medical – Faulkner County Employee Welfare Health Benefit Plan

Deductible for preferred provides: $500/individual, $750/family
Out-of-pocket limit for medical preferred providers: $5,000/individual, $8,000 family
Out-of-pocket limit for prescriptions: $2,600/individual, $5,200 family

Cost per pay period: Employee – no cost; employee and spouse - $240.50; employee and child - $230.00; employee and family - $245.50

Dental – Delta Dental

Pays 100% diagnostic and preventative services in-network
Deductible: $50 in-network
Annual maximum payment: $1,000 per person

Cost per pay period: Employee – no cost; Employee and family - $23.93

Vision – DeltaVision

Vision examination co-pay: $10
Materials co-pay: $25

Cost per pay period: Employee – no cost; Employee and Spouse - $1.74; Employee and Child - $2.32; Employee and Family - $5.09

Life Insurance – EMC

$50,000 life insurance coverage at no cost to employee; additional coverage available

Retirement – Arkansas Public Employees Retirement System (APERS)

As a condition of employment, percentage of pre-tax salary withheld for APERS, Faulkner County makes additional contributions on employee's behalf

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Supplemental Benefits

Retirement – Nationwide 457(b) Plan (Scott Curtis 334-546-5505)

Life Insurance –

Liberty National (Missy Collins 501-225-5556)
Boston Mutual (Carpenter-Belknap & Assoc., Inc. 800-225-8602)

Group Term Life Insurance – Liberty National (Missy Collins 501-225-5556)

Cancer -

Liberty National (Missy Collins 501-225-5556)
Aflac – (Joni Clark 501-428-4064)

Critical Illness – Aflac (Joni Clark 501-428-4064)

Long Term Care – Aflac (Joni Clark 501-428-4064)

KEY BENEFIT ADMINISTRATORS

Benefits Enrollment Form

Group Name: Faulkner County **Group #:** 9624

Please Print Clearly in Blue or Black Ink

Employee Last Name:	First Name:		MI	Date of Birth:
Phone Number:	Email Address:	❑ Male ❑ Female	Social Security #:	
Street Address:	City:		State:	Zip:

Please check *one* of the following: ❑ New employee[1] ❑ Current employee newly eligible for benefits[1] OR ❑ New Group Enrollment (KBA is new Plan Administrator)

[1]Attach a CERTIFICATE OF PRIOR CREDITABLE COVERAGE (CCC) from your previous insurance provider to avoid delays in the payment of your claims.

❑ Waive/Decline[2] all coverage for myself because ❑ I am covered through another plan OR ❑ I do not wish to enroll. I understand I may not be able to enroll at a later date.

❑ Waive/Decline[2] all coverage for my spouse: ❑ covered through another plan OR ❑ does not wish to enroll. I understand my spouse may not be able to enroll at a later date.

❑ Coverage is available from my spouse's employer and my spouse IS enrolled in that plan.

❑ Coverage is available from my spouse's employer and my spouse IS NOT enrolled in that plan.

[2]If you are declining enrollment for yourself or any dependents because of other coverage, you may in the future be able to enroll yourself or your dependent, provided you request enrollment within 30 days after the other coverage ends. 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 you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Coverage information: ***Please review each Plan Summary Plan Description or Enrollment Information Packet for important rules and guidelines.***

MEDICAL	❑**Enroll:** ❑Myself ❑Spouse ❑Child(ren) ❑**Waive/Decline:** ❑Myself ❑Spouse ❑Child(ren)	Coverage is available from my spouse's employer ❑ Yes ❑ No	
Other Insurance: Are you or any dependents covered under another **MEDICAL** plan? ❑No ❑Yes ❑Yes due to COBRA. If yes, including yes due to COBRA coverage, answer all remaining questions in this Medical section.		Carrier:	
Effective Date:	Policy #:	Policy Holder's Name:	Policy Holder's ID #/Medicare HIC#:
Employer:	Covered on Policy: ❑Myself ❑Spouse ❑Children (list names):		

Dependent Information: List all dependents below that you are enrolling per the benefits above. Use additional page if needed.

❑Spouse	Last Name:	First:	MI:	SS#:	DOB:	❑Male ❑Female

Last Name:	First:	MI:	SS#[5]:	DOB:	❑Male ❑Female
❑Child ❑Disabled[3] ❑Court ordered[4]					
Last Name:	First:	MI:	SS#[5]:	DOB:	❑Male ❑Female
❑Child ❑Disabled[3] ❑Court ordered[4]					
Last Name:	First:	MI:	SS#[5]:	DOB:	❑Male ❑Female
❑Child ❑Disabled[3] ❑Court ordered[4]					
Last Name:	First:	MI:	SS#[5]:	DOB:	❑Male ❑Female
❑Child ❑Disabled[3] ❑Court ordered[4]					
Last Name:	First:	MI:	SS#[5]:	DOB:	❑Male ❑Female
❑Child ❑Disabled[3] ❑Court ordered[4]					
Last Name:	First:	MI:	SS#[5]:	DOB:	❑Male ❑Female
❑Child ❑Disabled[3] ❑Court ordered[4]					

[3]For disabled dependents, SUBMIT appropriate documentation of disabled status with this enrollment form.
[4]If a Qualified Medical Child Support Order requires you to cover this dependent, SUBMIT that portion of the court order with this enrollment form.
[5]Please note that Social Security numbers are required on all covered dependents. Failure to provide may result in delays in the enrollment process.
Employee Signature: Sign, date, and return this form to your employer's HR department to implement the above enrollment/changes.

I hereby request coverage under the group policy(ies) offered by my employer and I authorize my employer to deduct from my earnings any required contributions. I am an eligible employee working the required hours per week for my employer. I hereby authorize hospitals, physicians, dentists, or other providers of service to furnish to Key Benefit Administrators, Inc., or its agents, upon request, any and all reports, records, or copies thereof concerning any illness, injury, or condition for which service was provided to me or my dependents together with like reports, records, or copies thereof of all earlier services.

Employee: ______________________________ **Employer Approval:** ______________________________
Signature Date Signature Date

EMPLOYER SECTION

Original Hire Date:	Full Time Hire Date:	Benefit Effective Date:

❑ **Reinstatement** of coverage effective _____/_____/_____ due to: ❑Return from lay-off ❑Return from leave ❑Rehired ❑Other: ____________________

KEY BENEFIT ADMINISTRATORS

Benefits Change Form – Page 1

Print clearly in blue or black ink. ☐ NOTE: Do not fill out page 2 unless you are ADDING dependents.

Group/Company Name: Faulkner County **Group #:** 9624 **Effective Date:** _____

Employee Full Name: _____ **Soc Sec #:** _____

Reason for Change:

☐ Termination	☐ Termination due to gross misconduct	☐ Loss of Benefit-Eligible Status
☐ Death	☐ Have secured other coverage	☐ Exceed plan age limit
☐ Retirement	☐ Divorce or Separation	☐ Open Enrollment
☐ Birth/Adoption	☐ Loss of Other Coverage	☐ Other _____

Under the terms of our policy, I hereby request Key Benefit Administrators, Inc. to make the following changes:

☐ CHANGE EMPLOYEE NAME to: _____

☐ CHANGE EMPLOYEE ADDRESS to: _____

☐ CHANGE PHONE NUMBER to: _____ ☐ CHANGE EMAIL to: _____

☐ CHANGE LOCATION to: _____ ☐ CHANGE ANNUAL SALARY to: _____

☐ CHANGE PRIMARY BENEFICIARY to: _____

☐ CHANGE SECONDARY BENEFICIARY to: _____

☐ TERMINATE COVERAGE for: ☐ Medical

☐ REMOVE DEPENDENTS – check all dependents you wish to **remove** and only check benefits you want to **drop**.

☐ Spouse for: ☐ Medical

☐ All children for: ☐ Medical

☐ Individual child _____
☐ Medical

☐ Individual child _____
☐ Medical

☐ Individual child _____
☐ Medical

☐ ADD DEPENDENTS – Note: If adding any dependents, ***you must complete page 2*** of this form.

:mployee Signature: Sign, date, and return this form to your employer's HR department to implement the above changes.

hereby request the above changes under the group policies offered by my employer and I authorize my employer to deduct from my earnings any required contributions. I am n eligible employee working the required hours per week for my employer. I hereby authorize hospitals, physicians, dentists, or other providers of service to furnish to mployee Benefit Services, Inc., or its agents, upon request, any and all reports, records, or copies thereof concerning any illness, injury, or condition for which service was rovided to me or my dependents together with like reports, records, or copies thereof of all earlier services.

mployee: _____ **Employer Approval:** _____
Signature Date Signature Date

KEY BENEFIT ADMINISTRATORS

Benefits Change Form – Page 2 – for dependent ADDITIONS.

☐ **Note:** Only fill out this page if you are **ADDING** dependents.

Employee Full Name: _____ **Social Security Number:** _____

Coverage Information: **This section is required if you are ADDING dependents. Only complete benefit sections these dependents will have.**

MEDICAL	**Add:** ❑Spouse ❑Child(ren) listed in the Dependent Information section below.	Coverage is available from my spouse's employer and my spouse is enrolled in that plan. ❑ Yes ❑ No	❑Primary Network: MMO-SuperMed Secondary Network: MultiPlan ❑Primary Network: First Health Secondary Network: MultiPlan
Are you or any dependents covered under another **MEDICAL** plan? ❑No ❑Yes ❑Yes due to COBRA. If yes, including yes due to COBRA coverage, answer all remaining questions in this Medical section.			Carrier:
Effective Date:	Policy #:	Policy Holder's Name:	Policy Holder's ID #
Employer:		Covered on Policy: ❑Myself ❑Spouse ❑Children (list names):	

Information: List all dependents that you are ADDING per the benefits above. Use additional page if needed.

❑Spouse	Last Name:	First:	MI:	SS#:	DOB:	❑Male ❑Female
Coverage to add for this dependent: ☐ Medical						

Child 1 Last Name:	First:	MI:	SS#[5]:	DOB:	❑Male ❑Female
❑Child ❑Disabled[3] ❑Court ordered[4]					
Coverage to add for this child: ☐ Medical					

Child 2 Last Name:	First:	MI:	SS#[5]:	DOB:	❑Male ❑Female
❑Child ❑Disabled[3] ❑Court ordered[4]					
Coverage to add for this child: ☐ Medical					

Child 3 Last Name:	First:	MI:	SS#[5]:	DOB:	❑Male ❑Female
❑Child ❑Disabled[3] ❑Court ordered[4]					
Coverage to add for this child: ☐ Medical					

Child 4 Last Name:	First:	MI:	SS#[5]:	DOB:	❑Male ❑Female
❑Child ❑Disabled[3] ❑Court ordered[4]					
Coverage to add for this child: ☐ Medical					

Child 5 Last Name:	First:	MI:	SS#[5]:	DOB:	❑Male ❑Female
❑Child ❑Disabled[3] ❑Court ordered[4]					
Coverage to add for this child: ☐ Medical					

Child 6 Last Name:	First:	MI:	SS#[5]:	DOB:	❑Male ❑Female
❑Child ❑Disabled[3] ❑Court ordered[4]					
Coverage to add for this child: ☐ Medical					

For disabled dependents, SUBMIT appropriate documentation of disabled status with this enrollment form.

If a Qualified Medical Child Support Order requires you to cover this dependent, SUBMIT that portion of the court order with this enrollment form.

Please note that Social Security numbers are required on all covered dependents. Failure to provide may result in delays in the enrollment process.