Authorized Broker Approval Form

BAPTIST HEALTH PLAN
651 Perimeter Drive, Suite 300, Lexington, KY 40517
Phone: 844.842.1510

1	Member Information
Member Name	
Mailing Address	
Street	
City/State/Zip	
Authorized Broker	

2	Member's Signature

_____ _____

First and Last Name **Date**

Enrollment/Change Form: Both pages must be received or the form will not be accepted by BHP.
Use this form to Enroll, Change, or Terminate (please print in black or blue ink)
Sign into the BHP secure portal and complete online: http://www.BaptistHealthPlan.com/

BAPTIST HEALTH PLAN
651 Perimeter Drive, Suite 300, Lexington, KY 40517
Phone: 800.787.2680 Fax: 859.335.3721 enrollment@baptisthealthplan.com

1 ENROLLEE INFORMATION

Social Security/Member Number	Last Name	First Name, MI	Gender ☐M ☐F	Date of Birth MM/DD/YY

Mailing Address	City	State	Zip	County

Home/Cell Phone	Email Address	Are you disabled? ☐Yes ☐No	Are you employed? ☐Yes ☐No

Employer Name and Address	Work Phone	Are you retired? ☐Yes ☐No

Type of Plan: ☐ Individual ☐ Individual/Spouse ☐ Individual/Child(ren) ☐ Family

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Note for Health Savings Account (HSA) enrollees: If you enroll in a Baptist Health Plan (BHP) HSA plan and need to open an HSA account, ConnectYourCare and HSABank have been contracted as a resource for our members. Visit www.baptisthealthplan.connectyourcare.com for more information or call 1.800.787.2680 for assistance.

Do you have a Primary Care Physician/ Practitioner (PCP)? ☐Yes ☐No	PCP's Name, Full Address (Street, City, State, Zip) and Phone Number

2 ENROLL

☐ Open Enrollment
☐ Native American Exemption*
☐ Loss of other coverage*

*Supporting Documentation Required

3 TYPE OF CHANGE

Add Dependent(s)
☐ Open Enrollment
☐ Newborn* ☐ Marriage*
☐ Adoption*
☐ Loss of other coverage*
☐ Other _____

Drop Dependent(s)
☐ Open Enrollment
☐ Divorce*
☐ Obtained other coverage
☐ Age Limit Exceeded
☐ Anticipation of Divorce

General
☐ Name*
☐ Address
☐ Telephone
☐ Other _____
_____

*Supporting Documentation Required

4 ENROLLEE TERMINATION

☐ Open Enrollment
☐ Termination of Employment
☐ Qualifying Event
☐ Term COBRA/Continuation
☐ Layoff
☐ Other _____

5 DEPENDENT INFORMATION and TOBACCO USAGE

List dependents applying for coverage (please check ☐ if you are using additional enrollment forms for more than 4 dependent children under the age 26). For court ordered dependent(s), legal documentation must be attached.

TOBACCO USAGE. Current or past tobacco usage for an average of 4 or more times a week within the past 6 months.

If a "Yes" response is given, include the date of the last time a tobacco product was used. Tobacco includes all tobacco products; however, religious or ceremonial uses of tobacco (for example, by Native American Indians and Alaskans) are specifically exempt from disclosure.

Add (A) Drop (D)	Relationship of Eligible Dependents	Full Name (Last, First, MI)	Date of Birth (MM/DD/YY)	Gender (Check One)	Social Security Number	Tobacco Usage & Date Last Used
N/A	Self (Enrollee)	Enrollee's response to Tobacco Usage Question	N/A	N/A	N/A	☐Yes ☐No
☐ A ☐ D	Spouse			☐ M ☐ F		☐Yes ☐No
☐ A ☐ D	Child 1			☐ M ☐ F		☐Yes ☐No
☐ A ☐ D	Child 2			☐ M ☐ F		☐Yes ☐No
☐ A ☐ D	Child 3			☐ M ☐ F		☐Yes ☐No
☐ A ☐ D	Child 4			☐ M ☐ F		☐Yes ☐No

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Enrollee Name _____

6 PRIOR COVERAGE

Have you or any dependents been covered by another health insurance plan at any time, including by BHP, during the last 12 months? ☐ Yes ☐ No

a. Name of Insured _____

b. Reason coverage terminated: _____

c. Type of plan ☐ Individual ☐ Individual /Spouse ☐ Individual /Child(ren) ☐ Family

d. Insurance Company Name: _____

e. Effective Date _____

f. Termination Date _____

7 OTHER HEALTH COVERAGE (This section must be completed)

a. Is your spouse employed? ☐ Yes ☐ No b. Employer _____

c. On the day your coverage begins, list family members, including yourself, who will be covered by Baptist Health Plan and any other health coverage including Medicare or retiree benefits ____

d. Insurance Company Name _____

e. Policy Number _____

f. Effective Date _____

g. Does this include a prescription benefit? ☐ Yes ☐ No

8 TERMS AND CONDITIONS

- I understand that I am responsible for promptly reporting any changes in my marital status, my number of eligible dependents or change in my residence to BHP.
- I hereby authorize any hospital, physician, surgeon, or pharmacist to release any information requested by BHP with respect to any claim of the delivery of medical care on behalf of myself or a covered dependent. A photocopy of this authorization will serve the same as the original. This authorization is not the same as a HIPAA Authorization.
- I agree that any medical benefits payable on my behalf under my Plan may be paid directly to the provider of care.
- I understand and agree that no benefits shall take effect until this enrollment/change form is approved by BHP. Upon such acceptance, BHP shall as soon as possible, issue an identification card(s) to me.
- I understand that I must be registered with the Bureau of Indian Affairs in order to receive the Native American Exemption.
- Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. (KY) KRS§304.47-030.
- It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage. (IN) IC§35-43-5-3.5.

PEDIATRIC DENTAL COVERAGE REQUIREMENT: I understand and agree that my health insurance plan purchased through Baptist Health Plan (BHP) may include pediatric dental benefits provided by Delta Dental as required by the Affordable Care Act (ACA) if I am under the age 21 and/or if I have dependents under the age 21 enrolled in my plan. It is further understood if I am required to have pediatric dental benefits for myself and/or my dependents under the age of 21 and if I purchase pediatric dental benefits through BHP, I must participate in the dental plan. I attest that I will have a pediatric dental benefit plan in force as of the effective date of this plan, meeting all federal and state requirements and such plan will remain in force during the entire contract period of the plan provided by BHP.

Enrollee Name (please print) _____ **Enrollee Signature** _____ **Date** _____

Health Insurance Premium Payment (HIPP) Program

The HIPP Program is administered by the Department for Medicaid Services and pays for the cost of private health insurance premiums. The Program reimburses individuals or employers for private health insurance payments for individuals who are eligible for Medicaid when it is cost effective. For more information or to see if you are eligible, contact the Department for Medicaid Services, HIPP Program at 770-980-9777, ext. 108, or 275 East Main Street, Frankfort, KY 40621