Confidential

DirigoChoice Discount Application

Your Name:_____Date:_____

Important

Did you:

✔ Complete and sign your *DirigoChoice* Discount Application?

✔ Place the white copy in this confidential envelope?

✔ Include any required documentation in this envelope (pay stubs, tax returns, etc.)?

✔ Seal the envelope?

✔ Keep the yellow copy for your records?

Please do not place your Harvard Pilgrim Health Care Member Enrollment/Member Change form in this confidential envelope.
If you have questions about applying for the *DirigoChoice* discount, please call 1-888-243-8731 toll-free in Maine.

Thank you for applying for DirigoChoice!

ACCOUNT NAME

STATEMENT OF TERMINATION OF DOMESTIC PARTNERSHIP

_____, being duly sworn, deposes and says that:
employee or domestic partner (print)

1. _____ and I are no longer domestic partners.
(name of employee or domestic partner)

2. I make and file this Statement of Termination in order to cancel the Affidavit of Domestic Partnership by me with **Account Name** on _____.
(effective date of termination)

   The above date is within 30 days of the termination of our domestic partnership.

3. I mailed my former domestic partner a copy of this notice at _____

   _____
   (former domestic partner's address)

   on _____.
   (date mailed)

I declare, under penalty of perjury, under governing state laws that the above statements are true and correct.

Signed: _____

Print: _____

Address: _____

_____

ACCOUNT NAME

AFFIDAVIT OF DOMESTIC PARTNERSHIP
(Maine)

I. DECLARATION

We, _____ and _____
employee (print) domestic partner (print)

certify that we are domestic partners in accordance with the following criteria and eligible for benefits coverage as domestic partners under **Account Name**'s benefits program.

II. STATUS

The employee and intended domestic partner must provide evidence attesting to the following eligibility requirements.

1. We are each other's sole domestic partner and intend to remain so indefinitely.

2. We are of the [same or opposite] sex and neither one of us is married to someone else.

3. We are at least eighteen (18) years of age and mentally competent to contract.

4. We reside together in the same residence, have done so continuously for the past 6-months and intend to do so indefinitely.

5. We are jointly responsible for our common welfare and financial obligations, and we attach to this Affidavit as evidence thereof a document which reflects our joint financial responsibilities, i.e. (copies of federal income tax return listing one of us as a dependent of the other, mortgages, leases, titles to real or personal property). **Account name** may reasonably request, as necessary, other documentation which reflects our joint financial responsibilities.

III. CHANGE IN DOMESTIC PARTNERSHIP

1. We agree to notify **Account Name**'s Human Resources Department or the appropriate equivalent if there is any change in our status as domestic partners as attested to in this Affidavit which would make us no longer eligible for **Account Name**'s benefits (for example, a change in joint-residence or if we are no longer each other's sole domestic partner). We will notify **Account Name** within thirty (30) days of such change by filing a Statement of Termination of Domestic Partnership ("Statement of Termination"). The Statement of Termination shall affirm that the Domestic Partnership status is terminated as of its date of execution and that a copy of the Statement of Termination has been mailed to the other party by the party authorizing such action.

2. After such termination I, _____,
(employee)
understand that a subsequent Affidavit of Domestic Partnership cannot be filed until twelve (12) months after a Statement of Termination has been filed with **Account Name**'s Human Resources Department. (The twelve (12) month waiting period will be waived only if another Affidavit is filed for the same domestic partner within thirty-one (31) days following the filing date of the Statement of Termination.)

IV. STATEMENT OF CONFIDENTIALITY

1. **Account Name** shall keep information obtained in the Affidavit of Domestic Partnership in the strictest confidence. Such information will not be used for any other purpose or released without the written consent of both parties except that **Account Name** shall provide a copy of this Affidavit to the health care carrier as evidence of eligibility.

V. ACKNOWLEDGEMENTS

1. We understand that any person/employer/company who suffers any loss due to any false statement contained in this Affidavit may bring a civil action against either or both of us to recover their losses, including reasonable attorneys' fees. Furthermore, we understand that if it is determined that any false statements are contained in this Affidavit or we fail to provide updated information as required herein, our health coverage may be terminated retroactive to the date this Affidavit was signed.

2. We have provided the information in this Affidavit for use by **Account Name**'s Human Resources Department for the sole purpose of determining our eligibility for domestic partnership benefits.

3. We affirm, under penalty of perjury, that the assertions in this Affidavit are true to the best of our knowledge.

VI. ACCOUNT NAME RIGHTS

1. **Account name** in accordance with the Plan's eligibility requirements, reserves the right to terminate, modify, or adjust this policy at any time and in its sole discretion.

Community Property Implications: Please be advised that some courts have recognized non-marital relationships as the equivalence of marriage for the purpose of establishing and dividing community property.

_____ _____

Employee signature Date

_____

_____

Employee address

_____ _____

Domestic partner signature Date

_____

_____

Domestic partner address

State of Maine

Authorization Agreement for Direct Deposit Services

Please **print in ink** or **type** all requested information

To: DirigoChoice Program
ATTN: Direct Deposit
153 State House Station
Augusta, ME 04333-0153
Phone#: 1-877-892-8391 Fax#: 207-287-9922 TTY#: 207-287-4344

You are hereby authorized to electronically transfer payments to the following:

Name of Financial Institution (Bank or Credit Union) _____ Transit/ABA/Routing Number _____

Type of Account: _____ Checking or _____ Savings – Statement Accounts only

Branch Address _____ City _____ State _____ ZIP Code _____ Bank Phone Number _____

Name(s) of Account Owner(s) *(Depositor)* _____ Account Number _____

for deposit to my/our account and I/we authorize the Agency to initiate credit and debit entries (to make corrections) to my/our account at the above named financial institution. Each deposit so made (after any necessary corrections) will be full payment of the amount then due and payable to me/us. I agree to notify the Agency's offices immediately upon discovery of any errors resulting from transactions under this authorization and to notify the Agency's offices of any changes that may affect these instructions or the Agency's ability to rely upon them. This authorization may be canceled by me/us at any time by so notifying the Agency in writing. In authorizing the above services to be provided to me/us, I/we agree to hold the Agency and the State of Maine harmless from any and all loss, cost, damage, or expenses I may suffer as the result of errors in deposits, credit entries or debit entries caused by persons who are not employees of the Agency or the State of Maine.

Signature of Depositor *(DirigoChoice Subscriber)* or Authorized Agent *(Guardian, Power of Attorney, etc.)* _____ Date _____ Social Security Number of DirigoChoice Subscriber _____

DirigoChoice Subscriber's Telephone Number: _____

Depositors: Address _____ City _____ State _____ ZIP Code _____

Title of Authorized Agent *(Guardian, Power of Attorney, etc.)* _____ Contact Person: Name: _____ Phone: _____

Always notify us in writing of any change in your name, address, bank account, etc.

PLEASE READ BACK OF FORM BEFORE COMPLETNG IT.

Authorization Agreement Instructions

PLEASE NOTE – If you qualify for a DirigoChoice discount and you have been enrolled in DirigoChoice for at least three months, you may apply to have your discount amount deposited directly into your checking or savings account by EFT (electronic funds transfer). Completed EFT form must be mailed to the DirigoChoice Program address listed on page 1 of this form.

During the first three months, your discount amount will be deposited on an EBT (electronic benefits transfer) debit card. You will get instructions on how to use your EBT card. Your EBT card will continue to be the way that you receive your discount until you have applied and are approved for EFT. Once approved for EFT, any remaining balance on your EBT account will automatically be transferred to your checking or savings account. If Direct Deposit fails, funds will go to the EBT card.

Name of Financial Institution: Bank or credit union where money will be direct deposited (Key Bank, Bank of America, etc.)

Transit/ABA Number: Usually found in the lower left corner of the voided check, or you can call your bank.

Type of Account: Please indicate checking OR savings – NOT BOTH! Direct Deposit can go to either type of account but cannot go to a C.D. (Certificate of Deposit). Also, payments cannot be deposited to your credit card. If you have a Passbook Savings account, please see your bank to verify whether they will allow debit entries to that account, or whether you need to change to a statement account.

Financial Institution Address and Telephone Number: Local bank office where business is usually conducted.

Name of Account Owner: This is the name on the account to which the check will be credited. If a joint account, both names should be identified.

Account Number: Account to which the money will be deposited.

Signature of Depositor or Authorized Agent: Signature of the person who is the DirigoChoice subscriber and the owner of the account, or the person authorized to act for the subscriber, legal guardian, conservator, parent of a minor child, or representative payee. This should not be a bank employee.

DirigoChoice Subscriber's Telephone Number: Telephone number where you can be reached for questions about your form, or where we can leave a message for you.

Address: Mailing address of the client or the Authorized Agent (if there is one).

Title of Authorized Agent: Power of Attorney, legal guardian, representative payee, parent. This is only required if you are filling out the form for someone else. If you are filling out the form for yourself, leave it blank.

Contact Person: Name and telephone number of person to contact, other than the client, if the bank does not accept the Direct Deposit for any reason. This should NOT be a bank employee. You may leave this blank if you do not want a contact person named.

DIRIGO HEALTH AGENCY PARTICIPATION AGREEMENT

THIS PARTICIPATION AGREEMENT describes the arrangement by and between The Dirigo Health Agency, an independent executive agency of the State of Maine and having a place of business located at 211 Water Street, Augusta, Maine 04330 (hereinafter sometimes referred to as the "DHA") and the DHA Employer (hereinafter sometimes referred to as the "DHA Employer").

WHEREAS, DHA has an agreement, the Dirigo Health Agency Group Health Insurance Agreement, with Harvard Pilgrim Health Care, Inc. for its affiliate, HPHC Insurance Company, Inc. (hereinafter sometimes referred to as "HPHC") to provide a certain healthcare benefit plan, the DirigoChoice PPO Plan (the "Plan"); and

WHEREAS, for administrative purposes the DHA is the policyholder of the insurance provided through the DHA; and

WHEREAS, the DHA Employer desires to purchase insurance and participate in the Plan through the DHA.

NOW, THEREFORE, in consideration of the mutual agreements and undertakings contained herein the parties agree as follows:

1. **Acceptance by DHA Employer.** This Participation Agreement will be deemed accepted by DHA Employer and binding upon both parties upon payment of DHA Employer's first month's premium.

2. **Participation Eligibility.** The DHA Employer agrees that in order to be eligible to participate in the Plan, it must pay the appropriate membership fee to DHA; must certify that at least seventy-five percent (75%) of its employees who work thirty (30) or more hours per week and who do not have other creditable health coverage are enrolled in the Plan; and must otherwise meet the minimum participation and other requirements specified in 24-A M.R.S.A. § 2808-B(4)(A). The DHA Employer further agrees to pay no less than sixty percent (60%) of the monthly cost of subscription charges for an individual rate for each of its employees covered under the Plan.

   The DHA Employer understands that its failure at any time during the Term of this Participation Agreement to meet all of the aforementioned criteria shall be cause for the DHA to terminate this Participation Agreement and for HPHC to terminate the coverage that it is providing to the DHA Employer under the Plan.

3. **Term and Termination.** The Term of this Participation Agreement shall be one year from the effective date to the next anniversary of the effective date. The "effective date" is the date the DHA Employer's contract with the DHA begins. This Participation Agreement shall then be automatically renewed for successive one-year terms on the anniversary date, unless sooner terminated as provided below.

   In addition to situations in Section 2 above, this Participation Agreement shall terminate automatically in the event that the Dirigo Health Agency Group Health Insurance Agreement between Harvard Pilgrim Health Care and the DHA terminates or expires. This Participation Agreement and the coverage being provided by HPHC under the Dirigo Choice Plan may be terminated at any time by DHA (1) for cause, including if the DHA Employer has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact, or (2) by mutual agreement of the parties.

   This Participation Agreement may also be terminated without cause upon thirty (30) days' prior written notice from one party to the other.

4. **Plan.** The DHA agrees to make available to DHA Employer at the HPHC negotiated rate the Plan which consists of one or more of three options, Option 1, Option 2, and Option 3 as set forth in the Dirigo Health Agency Group Health Insurance Agreement.

5. **Additional Obligations of DHA.**

   a. DHA has arranged for HPHC to issue an evidence of coverage and amendments specifying the essential features of the Plan to eligible employees and their eligible dependents (hereinafter sometimes collectively referred to as "Members"); to issue the Summary of Benefits to Members; and to issue identification cards to Members.

   b. DHA shall establish administrative and accounting procedures for operating the DHA and shall perform such additional and other activities as are necessary to administer the Plan and provide services to DHA Employer.

   c. DHA will hold an annual open enrollment period coinciding with the annual renewal of this Participation Agreement during which period eligible employees of the DHA Employer and their eligible dependents may enroll. The open enrollment will be for the thirty (30) day period beginning sixty (60) days prior to the expiration of the then current Participation Agreement. The enrollment of eligible employees and their eligible dependents, other than during annual open enrollment, shall take place in accordance with applicable law and the applicable evidence of coverage issued by HPHC. DHA Employer's employees and their dependents shall be eligible for coverage under the Plan if they meet the eligibility requirements of the DHA and HPHC as set forth in the Dirigo Health Agency Group Health Insurance Agreement and the Benefit Handbook.

   d. The Dirigo Health Agency Group Health Insurance Agreement provides that HPHC shall be the claims fiduciary and as such will receive, review, and act upon grievances of members covered under the Plan consistent with applicable regulations and law.

6. **Additional Obligations of DHA Employer.** DHA Employer:

   a. Agrees to provide HPHC with an Application for Group Insurance (AGI), the subscriber(s) application(s), the signed Rate Sheet, the Group Profile, and any other reasonable documentation required by the DHA or HPHC. DHA Employer further agrees to comply with the minimum participation requirements set forth in this Participation Agreement and in 24-A M. R. S. A. § 2808-B(4)(A) and acknowledges the right of DHA and HPHC to audit DHA Employer's payroll to verify that such requirements are met.

   b. Agrees to pay to DHA all subscription charges and membership fees in full by the due date on the invoice submitted to the DHA Employer by HPHC, acting on behalf of DHA. The monthly subscription charge will be set forth in the applicable Rate Sheet. The DHA Employer understands that if subscription charges and membership fees are not paid to DHA in full by the due date that HPHC, acting on behalf of DHA, may, with prior notice, terminate the DHA Employer's coverage. HPHC, acting on behalf of DHA, will send Notices of Termination to DHA Employer and subscribers in accordance with Maine law. Except for the first month, the Notice will be rescinded, if within the 30-day grace period, the DHA Employer makes full payment of all amounts owed to DHA. HPHC shall have no obligation to pay claims for services rendered after the date of termination of coverage, except for the grace period, unless coverage has been reinstated. Failure to pay subscription charges or membership fees to DHA in a timely manner shall constitute a material breach of this Participation Agreement.

c. Acknowledges that in the event that federal or state laws or regulations mandate a change in the benefits of the Plan or in the eligibility of Members, then DHA and HPHC will implement such mandatory changes. Such changes will be made on the effective date stated in the law. DHA Employer acknowledges further that its subscription charges may be adjusted during a twelve-month policy period if there is a change in law or regulation increasing DHA's or HPHC's cost of providing the Plan, including, but not limited to, the addition of any benefit or the imposition of any tax or surcharge that is effective prior to the next anniversary date of the Plan for DHA Employer. Any such adjustment will be indicated on the invoice to the DHA Employer. In the event that DHA and HPHC determine that subscription charges must be adjusted, then DHA or HPHC will give DHA Employer sixty (60) days' prior written notice.

If the DHA Employer becomes subject to federal or state laws requiring a benefit change, then DHA Employer will provide DHA and HPHC with notice of the change prior to the effective date and DHA and HPHC shall implement such mandatory changes. Such changes will be made on the effective date stated in the law, and if necessary to accommodate these changes, subscription charges may be adjusted and such adjustment will be indicated on the invoice to the DHA Employer. In the event that DHA and HPHC determine that subscription charges must be adjusted, then DHA or HPHC will give sixty (60) days' prior written notice.

d. Acknowledges that in the event DHA, or HPHC, acting on behalf of DHA, notifies the DHA Employer of a benefit and/or rate change, payment of billed charges indicates acceptance of the changes. DHA Employer is responsible for notifying covered employees of any changes in their contribution rates.

e. Agrees to be the "Plan Sponsor" and to act as or to appoint a third party to act as the "Plan Administrator" of its group health plan as those terms are defined in section 3(16) of the Employee Retirement Income Security Act of 1974 (ERISA) (29 U. S. C. § 1002(3)(16)). As provided by federal law, the Plan Sponsor and Plan Administrator (i.e., the DHA Employer and/or its appointee) shall be solely responsible for complying with the applicable provisions of the Internal Revenue Code (IRC) and ERISA (including the health insurance continuation requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and all applicable regulations. The DHA Employer acknowledges that neither the DHA nor HPHC is the Plan Administrator or Plan Sponsor of its group health plan. The DHA Employer is responsible for providing Members with all required notices and communications relating to their rights under ERISA or COBRA to elect to continue coverage upon termination of employment or other qualifying event. The DHA Employer further agrees that neither the DHA nor HPHC shall be liable for any claims or damages that may result from DHA Employer's failure to comply with any laws or regulations. Additionally, the DHA Employer agrees to hold the DHA and HPHC harmless from and against any liability that they may incur at any time due to the DHA Employer's failure to comply with any laws or regulations or to notify DHA and/or HPHC of any change in status of any Member.

f. Agrees to provide HPHC, acting on behalf of DHA, with any necessary financial statements and credit information.

g. Agrees to notify HPHC, acting on behalf of DHA, within thirty (30) days of any qualifying or disqualifying event.

h. Acknowledges that in the event that the DHA Employer terminates coverage purchased through the DHA, then the DHA Employer shall be ineligible to purchase a health benefit plan through the DHA

that includes the Plan discount program for a period of twelve months following such termination of coverage.

i. Agrees to offer only health plans procured through the DHA as long as this Participation Agreement is in effect.

j. Agrees to adhere to the enrollment and termination procedures of DHA and/or HPHC with respect to eligible employees and their eligible dependents.

k. Agrees to cooperate with DHA and HPHC in obtaining information concerning other insurance available to Members for purposes of coordinating benefits consistent with applicable law.

7. Third Party Beneficiary. HPHC is a third party beneficiary to this Participation Agreement. DHA Employer agrees and acknowledges that HPHC is a third party beneficiary to this Participation Agreement and that HPHC shall have authority to enforce any of its rights to the extent that they may be affected by this Participation Agreement, the actions or inactions of the parties thereto, or any of its provisions.

8. Miscellaneous Provisions.

a. This Participation Agreement constitutes the entire understanding of the parties and supersedes any and all prior understandings.

b. This Participation Agreement incorporates by reference the Application for Group Insurance, Group Profile Form, Rate Sheet, Dirigo Choice PPO Benefit Handbook and other applicable applications provided to DHA Employer pursuant to its participation under this Agreement.

c. This Participation Agreement will be governed by the laws of the state of Maine without regard to its rules regarding conflict of laws.

d. This Participation Agreement may be amended on DHA Employer's anniversary date or at any time upon mutual agreement of the parties.

e. DHA or HPHC, acting on its behalf, may use or disclose protected health information (PHI) in accordance with the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder.

f. Neither DHA nor HPHC, acting on its behalf, shall be required to perform any term, condition, or covenant in this Participation Agreement as long as such performance is delayed or prevented by any acts of God, strikes, lockouts, material or labor restrictions by any governmental authority, civil riot, floods, acts of terrorists, acts of war or terrorism, or any other cause not reasonably within the control of DHA or HPHC, acting on its behalf, and which by the exercise of due diligence DHA or HPHC, acting on its behalf, is unable, wholly or in part, to prevent or overcome.

g. The relationship between DHA or HPHC, acting on its behalf, and DHA Employer will be that of independent contractors. Each party is, and will continue to be an independent entity. Neither DHA nor DHA Employer is the employee, representative or agent of the other.

Applying/Renewing for DirigoChoice Coverage Through Your Employer

Enclosed is everything you need to apply or renew coverage through your employer. Be sure to keep a copy of these forms for your records. Please follow the steps below.

1 Member Enrollment/Member Change Form

- For new enrollment and renewals, you need to complete and sign the Member Enrollment/Member Change Form.
- Questions about completing this form? Please call your insurance producer/agent or call Harvard Pilgrim Health Care (HPHC) at 1-877-213-5225.

2 Discount Application

- For new and renewals, you need to complete and sign the DirigoChoice Discount Application (including income documentation if applying for a discount).
- Questions about completing this form? Please call the Dirigo Health Agency (DHA) at 1-877-892-8391 toll free in Maine (207-287-4344 TTY).

3 When you have completed both forms:

- Place your DirigoChoice Discount Application and income documentation **only** in the Confidential Envelope.
- Seal the Confidential Envelope and be sure to write your name and the date on the outside.
- Please return the **sealed** Confidential Envelope and your completed Member Enrollment/Member Change Form to your employer.

4 Next steps:

- The Dirigo Health Agency will review your new/renewal application.
- If you are applying for a discount, you will receive a letter. This letter will inform you of the assigned discount level.
- If you do not respond to the letter, you will be enrolled at the assigned discount level.
- If there are any questions about your application, you will be contacted.

Thank you for applying/renewing for coverage through DirigoChoice!

Applying/Renewing DirigoChoice Coverage for Self-Employed Person or an Individual

Enclosed is everything you need to apply or renew for coverage as a Self-Employed Person or as an Individual. Please be sure to keep a copy of these forms for your records. When forms are completed and signed, mail the forms in the envelope provided to DirigoChoice, 153 State House Station, Augusta, ME 04333-0153. Incomplete/missing information may delay the start of your coverage.

For new enrollment and renewals, complete, sign and return the Member Enrollment/Member Change Form.

Questions about completing this form? Please call Harvard Pilgrim Health Care (HPHC) at 1-877-213-5225.

For new enrollment and renewals, complete, sign, and return a DirigoChoice Discount Application (including income documentation if applying for a discount). Income information sent with your packet should accurately represent your present income.

For new enrollment and renewals, complete, sign and return the DirigoChoice Certification Statement.
Questions about completing these forms? Please call the Dirigo Health Agency (DHA) at 1-877-892-8391 toll-free in Maine (TTY 207-287-4344).

For new enrollment and renewals, choose a Plan Option, sign and return the Rate Sheet.

The Rate Sheet tells you the monthly rate quoted by HPHC, before any discount is applied. The signed Rate Sheet is required to process your application.

When you have completed all forms:
Mail the materials in the envelope provided to: DirigoChoice, 153 State House Station, Augusta, ME 04333-0153. Your application/renewal materials must be postmarked no later than the last day of any month, for an effective/continued date of coverage the 1st day of the 2nd month after the postmark. For example, application/renewal materials postmarked January 31st; coverage begins March 1st.

Next steps:

1. No payment is due at this time. You will receive a bill in the mail.
2. The Dirigo Health Agency will review the materials and decide if you are eligible for a discount.
3. The Dirigo Health Agency will send you a letter notifying you of your discount group.
4. New members will be sent the Dirigo Health Agency Participation Agreement. This is the contract between you and the Dirigo Health Agency. It will become effective upon your first monthly payment.
5. If there are any questions about your application, you will be contacted.
6. If you enroll/renew in DirigoChoice, you will have an annual membership fee that will be added to your monthly bill. The fee is $150 and will be divided over the plan year.

Thank you for applying/renewing coverage through DirigoChoice coverage!

Applying/Renewing DirigoChoice Coverage as a Small Business/Employer

Enclosed is everything you need to apply or renew for coverage as a Small Business/Employer. Please be sure to keep a copy of these forms for your records. When forms are completed and signed, mail the forms in the large envelope provided. Incomplete/missing information may delay the start of your coverage.

For new enrollment and renewals, employers need to complete and sign the Group Profile Form.

- Be sure to answer Questions 16 and 17.
- Sign and date page 2. Signature is required to process your application.

For new enrollment, employers need to complete the Application for Group Insurance Form.

Questions about completing these forms? Please call your insurance producer/agent or call Harvard Pilgrim Health Care (HPHC) at 1-877-213-5225.

Each enrolling/renewing employee needs to complete and sign a Member Enrollment/Member Change Form. For renewals, any employee adding or deleting an eligible dependent, address change, etc. needs to complete and sign a Member Enrollment/Member Change Form.

Questions about completing this form? Please call HPHC at 1-877-213-5225.

Each enrolling/renewing employee needs to complete and sign a DirigoChoice Discount Application.

Questions about completing this form? Please call the Dirigo Health Agency (DHA) at 1-877-892-8391 toll free in Maine (TTY 207-287-4344).

Employers need to choose a Plan option and sign the Rate Sheet.

The Rate Sheet tells you the monthly rate quoted by HPHC. The signed Rate Sheet is required to process your new or renewal application.

When you and your employees have completed all forms:

Each employee needs to place their copy of the DirigoChoice Discount Application in the Confidential Envelope with income documentation. Then they should:

- Seal the Confidential Envelope.
- Write their name and the date on the outside of the Confidential Envelope.

Employers need to place the following in the large mailing envelope:

- Completed Member Enrollment/Member Change Forms
- Confidential Envelopes (completed DirigoChoice Discount Applications inside)
- Completed Application for Group Insurance if new applicant
- Completed Group Profile Form for both new and renewal enrollment
- Signed Rate Sheet

Your application materials must be postmarked no later than the last day of any month, for an effective date of coverage the 1st day of the 2nd month after the postmark. For example, application materials postmarked January 31st; coverage begins March 1st.

Next steps:

The Dirigo Health Agency will review the materials.

- Then each enrolling employee will receive a discount determination letter.
- If the employee does not respond to the letter, they will be enrolled at the assigned discount level.
- If there are any questions about any employees' applications, the employee will be contacted.

As an employer, you will pay an annual membership fee.

- The annual fee is based on the number of enrolled employees.
  2-9 enrolled employees $150
  10-24 enrolled employees $250
  25-50 enrolled employees $350
- The fee will be divided over the plan year and added to the monthly bill.

New groups will be sent the Dirigo Health Agency Participation Agreement. This is the agreement between you and the Dirigo Health Agency. It will become effective upon your first monthly payment.

Thank you for applying/renewing for coverage through DirigoChoice!

Harvard Pilgrim Health Care

Health Care Coverage Waiver Form

Employer Company Name:_____

Employee Name: _____

On behalf of myself and my eligible dependents (if any), I waive the option to enroll in Harvard Pilgrim Health Care health insurance offered at this time by or through my employer for the following reason:

_____ I am covered under another plan as a spouse or dependant

_____ I am covered by, Medicare, non-group, or Veterans program

_____ I am covered under another plan sponsored by a second employer

For each person declining to enroll in Harvard Pilgrim at this time because of other health care coverage listed above, please provide the following information:

Subscriber Name: _____

Carrier Name: _____ Group/Policy Number: _____

_____ I am covered by another health plan sponsored by this employer

_____ I do not wish to participate on health care benefits at this time (I am declining health insurance entirely)

Notice of Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this health plan, provided that you request enrollment within 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 60 days after the marriage, birth, adoption, or placement for adoption.

I understand that any person choosing to enroll later must meet Harvard Pilgrim's requirements for eligibility and for late enrollees.

Employee Signature: _____ Date: _____

I affirm that the assertions in this form are true and complete to the best of my knowledge, and I understand that Harvard Pilgrim has the right to terminate coverage, retroactive to the effective date of coverage, for any material misinformation (including omissions) contained in this form.

Employer Signature: _____ Date: _____

DirigoChoice is underwritten by HPHC Insurance Company, Inc. (HPHC), an affiliate of Harvard Pilgrim Health Care, Inc.

DirigoChoice

Harvard Pilgrim Health Care

Group Profile Form

Business Name: _____ **Primary Nature of Business:** _____

1. Business structure: _____
2. How long has your business been in operation? _____
3. Business in active operation: ❑ Year-round ❑ Seasonal (from _____ to _____)
4. Is your business eligible to file a combined state tax return with any other business? ❑ Yes ❑ No
5. Is your business affiliated with another business? ❑ Yes ❑ No
6. If you checked "Yes" in (4) or (5), all businesses in (4) and/or (5) are considered one group.
   Are all eligible employees and owners of all businesses in (4) and/or (5) considered eligible for your group plan? ❑ Yes ❑No
   If you checked "No," please explain: _____
7. Do at least 50% of your eligible employees work in Maine? ❑ Yes ❑ No
8. Do you offer another group health plan? ❑ Yes ❑ No If "Yes," name of carrier: _____
9. In the past 12 months, has your employer group participated in a health plan? ❑ Yes ❑ No
10. Does at least one eligible employee or owner work at least 30 hours per week? ❑ Yes ❑ No
11. Are all eligible employees and owners connected to the business through the documentation outlined on the Group Profile Form Instructions and Additional Information page? ❑ Yes ❑ No
    If you checked "No," please explain: _____

Definitions

Eligible Employee: An owner or employee who has worked the Minimum Hours for eligibility through the entire waiting period and continues to work the Minimum Hours for eligibility. Owners and employees must work the Minimum Hours for more than 26 weeks per year in order to be eligible.

Minimum Hours: The lowest number of hours per week that employees and owners must work in order to be eligible for coverage in your group health plan as specified by you, the employer. For *DirigoChoice*, Minimum Hours for eligibility must be between 20 and 40 hours per week.

Waiting Period: The period of time from the date that a person begins to work your group's Minimum Hours or more per week until the date that he or she is eligible for coverage in your group's health plan.

In answering questions 12 – 15, please refer to the above definitions of Eligible Employee, Minimum Hours, and Waiting Period.
Do not include employees or owners who are still in their Waiting Period in your responses.

12. How many Eligible Employees do you have? _____
13. How many Eligible Employees are not enrolling due to other coverage? _____
14. How many Eligible Employees are not enrolling and do not have other coverage? _____
15. How many Eligible Employees are enrolling? _____

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The total of your responses to Questions 13, 14, and 15 from the previous page must equal your response to Question 12. A minimum of 75% of Eligible Employees must participate, calculated as follows:

$$\frac{\text{(Response to Question 15)}}{\text{(Response to Question 12) – (Response to Question 13)}} = \text{\% of Eligible Employees}$$

16. What is group's waiting period? _____

17. What is your contribution level(s)?

	Employer Contribution: Employee	**Employer Contribution: Dependents**
Full-time (30+hours)	_____%	_____%
Part-time (25-29 hours)	_____%	_____%
Part-time (20-24 hours)	_____%	_____%

18. Do you sponsor a Section 125 plan? ❑ Yes ❑ No

Employer Certification

1. I am the authorized benefits administrator acting on behalf of _____ (the group).

2. The information provided in the Group Profile Form is true and correct. I understand that the Group Profile Form is part of the contract between the group and HPHC.

3. I understand that employees and owners are required to work at least the Minimum Hours per week through the entire Waiting Period in order to be eligible to enroll in the group health plan. I understand that employees and owners must continue to work at least the Minimum Hours per week in order to remain eligible for continued enrollment in the group health plan.

4. I understand that, in addition to working at least the Minimum Hours and satisfying the Waiting Period, employees and owners must be connected to the group through acceptable eligibility documentation (as outlined on the Group Profile Form Instructions and Additional Information page) in order to be eligible to enroll and to remain eligible for continued enrollment in the group health plan.

5. I understand that HPHC must be notified when an enrolled employee, owner, or dependent becomes ineligible for the group health plan. I understand that HPHC may not be responsible for any claims or expenses associated with an employee, owner, or dependent who is not eligible for the group health plan. I understand that any employee, owner, or dependent who is not eligible for the group health plan may be removed from the group health plan as of the date that the person was first ineligible.

6. I understand that HPHC is authorized to conduct an eligibility review of my group and of any member(s) of the group at any time. I understand that payroll records, tax filings, and other documentation requested through an eligibility review must be provided to HPHC upon request. I understand that failure to comply with an eligibility review could result in cancellation of the group health plan.

_____ _____ _____

Print Name Authorized Signature Date

Group Profile Form Instructions and Additional Information

The Group Profile Form addresses eligibility for coverage. These instructions explain some terms used on the Group Profile Form and provide guidance for responding to some of the questions on the form.

Question (1)

This question asks how your business is organized. Your response to this question should be the structure that applies to your company.

- Sole Proprietorship
- Limited Liability Company (LLC)
- S Corporation
- Corporation
- Partnership
- Non-Profit
- Other (please explain)

Question (5)

"Affiliated" is defined as a group of 2 or more businesses in which more than 50% of the ownership is in common.

Question (7)

In responding to this question, you must consider all employees and owners who work at least the Minimum Hours for eligibility. This includes employees and owners enrolling, waiving coverage, or within the Waiting Period.

Question (11)

A group must be actively engaged in business in order to be eligible. Individuals who are required to receive compensation that meets the minimum wage requirements are expected to receive compensation for at least the minimum wage for the group Minimum Hours per week. Individuals who are required to be reflected on a Maine 941 Form are expected to appear on the Maine 941 Form.

Formal payroll records for the most recent two pay periods referencing withholdings and deductions are acceptable for individuals who are not required to appear on a Maine 941 Form, such as owners, family members of owners (spouse, parent, children under 18), and new hires.

Owners may be connected to the business through the most recent set of business tax returns (Schedule C, Schedule F, 1120S and K-1, 1065 and K-1). Owners and family members of owners (spouse, parent, and children under 18) can be connected to the business by demonstrating signature authority for at least the past six months through an active business checking account signature card in the name of the business.

A business with only two eligible employees and owners working at least the group Minimum Hours per week may establish eligibility as set forth above (including employer and producer affidavits if a business signature card is submitted), or through one of the following:

- Workers' compensation insurance audit or evidence of a waiver of benefits under Title 39-A M.R.S.A.
- A description of operations in a commercial general liability or equivalent policy providing coverage for the business.

Question (17)

Employer minimum contribution requirements for *DirigoChoice* are based on employee-only premium:
Full-time (30+ hours) 60% of employee-only premium
Part-time (25-29 hours) 50% of employee-only premium
Part-time (20-24 hours) 40% of employee-only premium
Employer contribution for employee dependents is voluntary.

Question (18)

Please direct any questions about Section 125 plans to your tax professional.

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DirigoChoice

Group Information Form

Company Name:	

Company Location:

Address		
City _____	State _____	Zip _____-____
Phone (___)-___-____	Fax (___)-___-____	

Billing Location (If different from above):

Address		
City _____	State _____	Zip _____-____
Phone (___)-___-____	Fax (___)-___-____	

Contact Information:

Contact type	**Name**	**Phone number**	**Email**
Executive		(___)-___-____	
Billing		(___)-___-____	

Company Information:

Effective Date		Tax ID			
SIC Code		Industry			
Total Employees		Part-time		Full-time	
Total Eligible Employees		Part-time		Full-time	
Retirees under 65		Retirees over 65		Working Aged	
COBRA					

Broker Information*:

		Phone number
Broker Name		
Brokerage Firm Name		
Broker Mailing Address		
Broker Tax ID		**Email:**
Who is Commission Payable to?		

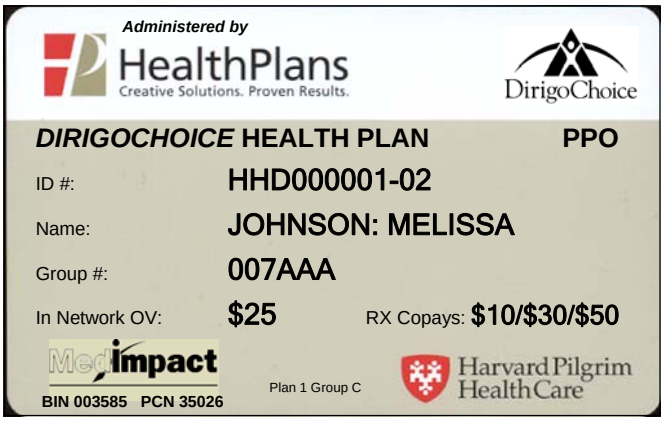
*Please fill and submit the Identification of Third-Party Representatives form.

Requested Plan Information:

Requested Plan selection:	☐ Plan 1 (small groups only)		☐ Plan 2		☐ Plan 3			
Proposed Rates:	EE only	$_____	EE & Spouse	$_____	EE & Child(ren)	$_____	Family	$_____

The foregoing statements are (1) true and correct to the best of my knowledge and belief and (2) made to induce the issuance of health coverage.

In Maine, It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.



www.healthplansinc.com

DEDUCTIBLE AND/OR CO-INSURANCE MAY APPLY

Notice to Members:

- For Customer Service call: **1-877-213-5225.**
- In a medical emergency, go to the nearest emergency facility or call **911** or other local emergency number.
- If hospitalized, notify the Plan at **1-877-213-5225** within 48 hours.
- Contact the Plan at **1-877-213-5225** to request approval for:
  - admission to a non-participating hospital
  - admission by a non-participating physician
  - all services listed on the Schedule of Benefits requiring approval.
- If out-of-area, call PHCS at **1-800-678-7427** for a listing of participating providers.

Notice to Providers:

- Participating providers must call **1-877-213-5225** for prior approval or to verify benefits.
- **Mail all claims to: Health Plans, Inc. PO Box 5199, Westborough, MA 01581**
- **WebMD Payor ID #: 44273**
- Pharmacy Help Desk: **1-800-788-2949.**

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Rev HPHC/HPI DC 1-08

DirigoChoice

Harvard Pilgrim Health Care

Certification Statement

To apply for *DirigoChoice* coverage as Self-employed or as an Individual, you must check one of the boxes below. If you have any questions about this form, please call the Dirigo Health Agency at 1-877-892-8391 toll free in Maine (TTY 207-287-4344).

❑ A. The following statement is true:
I am self-employed and have no employees

❑ B. The following statement is true:
I am unemployed.

❑ C. The following two statements are true:
(1) I do not work more than 20 hours a week for any single employer.
(2) I am not self-employed and I am not the employer of an eligible business of 2 to 50 employees.

❑ D. The following two statements are true:
(1) I am employed in an eligible business of 2 to 50 employees. I am not the employer.
(2) My employer does not provide access for me and my dependent(s) to an employer sponsored health benefits plan and has not done so in the last 12 months.

❑ E. The following two statements are true:
(1) I am the employer or I am an employee of an eligible business of 2 to 50 employees.
(2) *DirigoChoice* was offered to the employees. We were unable to get 75% participation.

Attached is a signed letter detailing efforts specific to offering *DirigoChoice* to the employees. The employer letter includes (a) intended contribution level; (b) the number of hours an employee must work each week to qualify for coverage in the business; and (c) the number of full-time employees working 30 or more hours per week and the number of part-time employees.

❑ F. The following statement is true:
I am an early retiree (*i.e.*, under age 65) who worked for an eligible business of 2 to 50 employees. My former employer does not contribute to early retiree health insurance coverage.

❑ G. All three of the following statements are true:
(1) I am employed by a household and I work more than 20 hours a week (for example: nanny, housekeeper).
(2) I am not self-employed. The household is considered my employer. My employer does not provide access for me and my dependent(s) to an employer sponsored health benefits plan and has not done so in the last 12 months.
(3) I am not the employer of an eligible business of 2 to 50 employees.

❑ H. The following statement is true:
I am eligible to apply for the Health Coverage Tax Credit (HCTC) Program certified under the Trade Adjustment Assistance Act.

In signing this statement I certify:
I meet the eligibility requirements checked above. I reside in the State of Maine and have for at least the last 60 days. As a new enrollee I am not currently eligible for Medicare. My dependent(s) also meet the eligibility requirements if I am covering them. I will contact the Dirigo Health Agency if my circumstances change. I understand that failure to do so may result in loss of coverage. I understand I may be required to recertify my status every six months.

Signature:_____ **Print Name:** _____ **Date:** _____

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DirigoChoice

Harvard Pilgrim Health Care

DirigoChoice Discount Estimator Worksheet

DirigoChoice offers discounts on: (1) the monthly cost of coverage, and (2) deductibles and out-of-pocket costs. There are 4 discount groups (B-E) that range from 20% to 80% depending on income and other factors. Upon receipt and review of your application, you will receive a written notice to let you know if you are eligible for *DirigoChoice* and what discount group you qualify for.

You can use this worksheet to estimate your discount group. **You do not need to return this worksheet.** It might be helpful to fill in this worksheet with your HPHC appointed insurance producer. When you apply, you will get a rate quote from your HPHC appointed insurance producer or HPHC directly. **If you qualify for a discount, your final cost will be lower than the quote**. If you have any questions or if you want an estimate for your discount level, call the *Dirigo Health Agency* at 1-877-892-8391 or TTY (207) 287-4344.

Step 1: Enter your personal information.

Please note: The financial information must be annual numbers.

1. Household Size _____	Household size equals the applicant plus all dependents. Dependent means an applicant's spouse or domestic partner, an unmarried child less than 23 years of age who qualifies as a dependent for tax purposes, or a person of any age who is the child of a plan enrollee and is disabled and dependent upon that plan enrollee. Child means a natural child, stepchild, adopted child or child placed for adoption with a plan enrollee.

What Is Counted		**Annual Amount**	**Where to Find It on Most Recent Federal 1040 Tax Return. Income information should accurately represent your present income.**
2. Annual Earned Income	**2.a** Applicant Gross Wages, Tips and Salaries (before any deductions)	$	Recent pay stubs, a signed letter from an employer, or a copy of the employer payroll. If not available, use Form 1040 Line 7 ("Wages, salaries, tips, etc.") or wages as reported on W-2. Do not use line 37 ("Adjusted Gross Income"). Multiply weekly income by 52 or bi-weekly income by 26 to get yearly income. Multiply monthly income by 12 to get yearly income.
	2.b Spouse or Domestic Partner Gross Wages (before any deductions)	$	
	2.c Net Self-Employment Income (gross receipts minus allowable business expenses)	$	Form 1040 line 12 "Business income or (loss)". We also accept IRS Quarterly Estimate of Earnings.
3. Annual Other Income	**3.a** Interest and investment income (savings accounts, dividends from stocks, bonds, trusts, mutual fund shares)	$	Form 1040 Line 8a and Line 9a, or annual interest income statements
	3.b Alimony Received	$	Form 1040 Line 11, divorce settlement order, or copy of check(s)
	3.c IRA Distributions	$	Form 1040 Line 15a (or Line 15b if Line 15a is blank)
	3.d Pensions, Annuities, 401(k)	$	Form 1040 Line 16a (or Line 16b if Line 16a is blank, checks, award letters, signed letter from payer)

DirigoChoice

Harvard Pilgrim Health Care

What Is Counted		Annual Amount	Where to Find It on Most Recent Federal 1040 Tax Return. Income information should accurately represent your present income.
3. Annual Other Income	**3.e** Net rental income (gross rents minus allowable expenses), royalties, trusts, etc.	$	Form 1040 Line 17
	3.f Farm income or loss	$	Form 1040 Line 18
	3.g Unemployment Compensation	$	Form 1040 Line 19, checks, award letters
	3.h Gross Child Support Received	$	Support orders, checks, check stubs
4. Income Subtotal ***(Total of Lines 2.a through 3.h)***		**$**	
5. Child-Related Annual Allowable Deductions	**5.a** Childcare Expenses	$	We allow $200 per child per month if under 2, $175 per child per month if 2 or older. Caregiver must be a person outside the household. Provide a receipt, copy of check, or letter from caregiver.
	5.b Child Support paid out (only allowed for children who will not be covered by the applicant's policy)	$	Checks, check stubs, support orders
6. Deductions Subtotal ***(Total of Lines 5.a plus 5.b)***		**$**	
7. Income Total ***(Number 4 minus Number 6)***		**$**	This is only an estimate. Eligibility representatives will make the final decision on applicant income and discount group.
NOTE: Social Security, Railroad Retirement, Worker's compensation payments and disability payments such as Veteran's Affairs disability are not counted as income.			

Step 2: Determine Your Discount Group.

On the Discount Group Chart find your household size (as entered on Number 1 above) in the left column. Then go right until the amount in the column is greater than your total income (as entered on Number 7 above). Then read up to see your discount level. For example, if you have a household size of 4 and you estimated your household income as $46,000, you would be in Group D. If you have a household size of 2 and your annual household income is $24,000, you would be in Group C.

Discount Group	B	C	D	E
Discount	80%	60%	40%	20%
Household Size	Annual Income Less Than:			
1	$15,600	$20,800	$26,000	$31,200
2	$21,000	$28,000	$35,000	$42,000
3	$26,400	$35,200	$44,000	$52,800
4	$31,800	$42,400	$53,000	$63,600
5	$37,200	$49,600	$62,000	$74,400
6	$42,600	$56,800	$71,000	$85,200

DirigoChoice

Harvard Pilgrim Health Care

Step 2A: What If I Don't Qualify for a Discount?

You can still participate in *DirigoChoice* with the following deductible and out-of-pocket cost.

	Plan 1	Plan 2	Plan 3
Single Deductible	$1,250	$1,750	$2,500
Single annual out-of-pocket	$4,000	$5,600	$3,500
Family Deductible	$2,500	$3,500	$5,000
Family annual out-of-pocket	$8,000	$11,200	$7,000

Available to small groups only under Plan 1:
- Single: $750 deductible/$2,400 annual out-of-pocket
- Family: $1,500 deductible/$4,800 annual out-of-pocket

Available to small groups only under Plan 2:
- Single: $1,125 deductible/$3,600 annual out-of-pocket
- Family: $2,250 deductible/$7,200 annual out-of-pocket

Step 3: What Does Your Discount Group Mean?

(1) Discount on the monthly coverage payments. This discount applies to the employee share of the health coverage costs after a minimum employer contribution of 60% of the single contract tier for full-time employees (may be prorated for employees who work more than 20 but less than 30 hours per week for a single employer).

(2) A self-employed person will contribute the minimum employer contribution of 60% of the single contract tier and will receive any discount for which he/she is eligible on the remaining balance of the payment Self-employed people and individuals are eligible for Plans 2 and 3.

(3) Reductions in deductibles and out-of-pocket costs.

Group B — 80% Discount		Deductible	Out-of-Pocket
Plan 1	Single	$ 250	$ 800
	Family	$ 500	$1,600
Plan 2	Single	$ 500	$1,600
	Family	$1,000	$3,200
Plan 3	Single	$ 500	$ 700
	Family	$1,000	$1,400
Group C — 60% Discount		Deductible	Out-of-Pocket
Plan 1	Single	$ 500	$1,600
	Family	$1,000	$3,200
Plan 2	Single	$ 800	$2,600
	Family	$1,600	$5,200
Plan 3	Single	$1,000	$1,400
	Family	$2,000	$2,800
Group D — 40% Discount		Deductible	Out-of-Pocket
Plan 1	Single	$ 750	$2,400
	Family	$1,500	$4,800
Plan 2	Single	$1,125	$3,600
	Family	$2,250	$7,200
Plan 3	Single	$1,500	$2,100
	Family	$3,000	$4,200
Group E — 20% Discount		Deductible	Out-of-Pocket
Plan 1	Single	$1,000	$3,200
	Family	$2,000	$6,400
Plan 2	Single	$1,450	$4,600
	Family	$2,900	$9,200
Plan 3	Single	$2,000	$2,800
	Family	$4,000	$5,600

DirigoChoice Discount Application

Information Provided on This Form Is Strictly Confidential

SECTION 1: GENERAL INFORMATION

1. Applicant Information:

Last Name _____ First Name _____

Mailing Address (Street or PO Box) _____

City _____ State _____ ZIP Code _____

If different from your mailing address, write the address where you actually live:

_____

Home Telephone _____ Work Telephone _____

Mobile Telephone _____ Email address _____

Are you a resident of the State of Maine? ❑ Yes ❑ No

1(a). Were you covered by another health insurance plan for all 12 months prior to applying for *DirigoChoice*?
❑ Yes ❑ No *If no, go to **1(e).***

1 b). How much was your deductible on the plan you had before?
Single $ _____ ❑ Unsure Family $ _____ ❑ Unsure

1(c). What was the coverage? Check all that apply:
❑ MaineCare ❑ Military/VA ❑ HPHC ❑ Aetna ❑ Cigna
❑ Anthem Blue Cross /Blue Shield ❑ Other (specify)_____

1(d). Was the coverage offered through your employer? ❑ Yes ❑ No

1(e). If you are applying to cover dependents through *DirigoChoice*, please tell us whether they had health insurance for all 12 months prior to applying for *DirigoChoice*?
Spouse/Domestic Partner: ❑ Yes ❑ No Dependent Child(ren): ❑ Yes ❑ No

2. Discount Request:

❑ I want to apply for a discount.

❑ I **do not** want to apply for a discount. *(If you do not want to apply for a discount, go to SECTION 3. Be sure to sign and date the application.)*

SECTION 2: *DIRIGOCHOICE* DISCOUNT INFORMATION

3. Household members and relationship:

Last name	First name	M.I.	Sex	Relationship to you	Social Security Number	Date of Birth

4. Household Wages:

Attach copies of paychecks, pay stubs, other proof of wages, or a copy of your most recent Federal 1040 tax return. Income information should accurately represent your present income.

What Is Counted	Annual Amount	Where to Find it on Most Recent Federal 1040 Tax Return
4(a). Applicant gross wages, tips and salaries (before any deductions)	$	Recent pay stubs, a signed letter from employer, or a copy of employer payroll. If not available, use Form 1040 line 7 ("wages, salaries, tips, etc.") or wages as reported on W-2. Do not use line 37 ("Adjusted Gross Income"). Multiply weekly income by 52 or bi-weekly income by 26 to get yearly income. Multiply monthly income by 12 to get yearly income.
4(b). Spouse or Domestic Partner gross wages (before any deductions)	$	
4(c). Net self-employment income (gross receipts minus allowable business expenses)	$	Form 1040 Line 12 "Business income or (loss)." We also accept IRS business Quarterly Estimate of Earnings.
Annual Other Income		
4(d). Interest and investment income (savings accounts, dividends from stocks, bonds, trusts, mutual fund shares)	$	Form 1040 Line 8a and Line 9a, or annual interest income statements
4(e). Alimony received	$	Form 1040 Line 11, divorce settlement order or copy of check
4(f). IRA distributions	$	Form 1040 Line 15a, or Line 15b if Line 15a is blank
4(g). Pensions, annuities, 401(k)	$	Form 1040 Line 16a, or Line 16b if Line 16a is blank, or checks, award letters, signed letter from payer

4(h).	Net rental income (gross rents minus allowable expenses), royalties, trusts, etc.	$	Form 1040 Line 17
4(i).	Farm income or loss	$	Form 1040 Line 18
4(j).	Unemployment compensation	$	Form 1040 Line 19, checks, award letters
4(k).	Gross child support received	$	Support orders, checks, check stubs

5. Income Subtotal $

Total of 4(a) through 4(k)

6. Child-Related Annual Allowable Deductions

6(a).	Childcare expenses	$	We allow $200 per child per month if under 2, $175 per child per month if 2 or older. Caregiver must be a person outside the household. Provide a receipt, copy of check, or letter from caregiver.
6(b).	Child support paid out (only allowed for children that will not be covered by the applicant's policy)	$	Checks, check stubs, support orders

7. Deductions Subtotal $

Total of 6(a) and 6(b)

8. Income Total $

(Line Number 5 minus Line Number 7)

SECTION 3: SIGNATURE OF APPLICANT

9. I understand the questions on this form. All statements and answers I have given are true and complete. The *Dirigo Health Agency* may check information submitted on this form. I understand it is a crime to knowingly provide false, incomplete or misleading information on this form and that I could be charged with perjury.

Signature **Date**

HPHC Insurance Company
DirigoChoice PPO Plan
Enrollment / Change Form

PO BOX 5255 • WESTBOROUGH, MA 01581
1-877-213-5225 www.healthplansinc.com

REASON FOR SUBMISSION (PLEASE CHECK ALL THAT APPLY)

☐ ENROLLMENT
- ☐ NEW HIRE ☐ COBRA
- ☐ ANNUAL OPEN ENROLLMENT £ RENEWAL
- ☐ LOSS OF INSURANCE DATE _____ (ATTACH DOCUMENTS)
- ☐ P/T TO F/T DATE _____

☐ CHANGE
- ☐ CHANGE COVERAGE TYPE
- ☐ ADD DEPENDENT LISTED BELOW
- ☐ TERMINATE DEPENDENT LISTED BELOW

☐ NAME/ADDRESS CHANGE
- ☐ LOSS OF INSURANCE DATE _____ (ATTACH DOCUMENTS)
- ☐ MARRIAGE DATE _____
- ☐ NEWBORN DATE _____

☐ TERMINATION
- ☐ LEFT EMPLOYMENT ☐ NO LONGER ELIGIBLE
- ☐ VOLUNTARY CANCELLATION ☐ DECEASED DATE _____
- ☐ MOVED FROM SERVICE AREA
- TERMINATION DATE _____

TO BE COMPLETED BY HPHC ONLY.	GROUP / COMPANY NAME (IF APPLICABLE)	DATE OF HIRE	GROUP #/DIVISION (IF APPLICABLE)	EFFECTIVE DATE
H H D				

APPLICANT NAME

FIRST MIDDLE LAST

ADDRESS

APT. NO. STREET PO BOX

CITY STATE ZIP COUNTY

TELEPHONE (HOME) ( )

TELEPHONE (WORK) ( )

TYPE OF COVERAGE
- ☐ INDIVIDUAL ☐ 2-PERSON
- ☐ FAMILY ☐ OTHER _____

PLEASE USE THE CODES LISTED BELOW TO COMPLETE DEPENDENT RELATION BLOCK

02 SPOUSE / DOMESTIC PARTNER
03 DEPENDENT CHILD UNDER 23
04 STEPCHILD UNDER 23
06 HANDICAPPED (VERIFICATION REQUIRED)

FIRST MI LAST (IF NOT SAME AS APPLICANT)	LANGUAGE CODE	DATE OF BIRTH MO DAY YR	SEX		RELATION CODE	SOCIAL SECURITY NUMBER
APPLICANT		- -	M	F	01	- -
SPOUSE		- -	M	F		- -
DEPENDENT		- -	M	F		- -
DEPENDENT		- -	M	F		- -
DEPENDENT		- -	M	F		- -
DEPENDENT		- -	M	F		- -

LANGUAGE CODES (OPTIONAL)

WHAT LANGUAGE DO YOU SPEAK MOST OFTEN? PLEASE LIST THE APPROPRIATE CODE AFTER EACH MEMBER'S NAME. THIS INFORMATION WILL HELP US WORK TOWARD BEST MEETING YOUR NEEDS.

AS American Sign Language · CA Cantonese · CV Cape Verdean · EN English · FR French · HA Haitian · HM Hmong · IT Italian · KH Khmer · LO Laotian · MN Mandarin · PT Portuguese · RU Russian · SP Spanish · VI Vietnamese · OTHER ☐ _____ Specify

HAVE YOU EVER BEEN A MEMBER OF HPHC, HPHC OF NE, OR HPHC INSURANCE COMPANY? ☐ YES ☐ NO

IF YOU WOULD LIKE TO RECEIVE A MENU OF ELECTRONIC WAYS TO INTERACT WITH US, LIST YOUR E-MAIL ADDRESS HERE.

E-MAIL ADDRESS: _____ (OPTIONAL)

YOUR E-MAIL ADDRESS WILL BE STORED IN A PROTECTED DATABASE AND WILL REMAIN CONFIDENTIAL.

Membership will become effective upon acceptance by HPHC. Benefits under the Plan will be explained in a separate document. For an explanation of how HPHC may use or disclose your protected health information, please read your notice of privacy practices provided to you by HPHC in your enrollment kit. Please note that the subrogation provision applicable to Maine members, outlined in a separate document, permits subrogation payments on a just and equitable basis. I understand that by signing below, I am agreeing to the terms of the evidence of coverage. All statements and descriptions in this enrollment/change form are deemed to be representations and not warranties. I authorize any health care provider or other health plan to provide medical information and records to HPHC. I also authorize the plan and any health care provider rendering services to me or my dependents to receive copies of my or my dependents' medical records. I understand that any information obtained under this authorization will be used in the delivery of health services, to determine eligibility for benefits (including reimbursement by third parties), in education and research in accordance with government regulations, and in connection with HPHC's professional and utilization review activities. Permission is not given for any re-disclosure of this information other than as specified above. This authorization is valid for the term of the policy and any renewals of that policy. I understand that a copy of this form will be given to me, or my authorized representative, upon request. I understand that I may revoke this authorization, but that a revocation may be a basis for denying insurance benefits. Failure to sign this form may impair the ability of HPHC to evaluate or process your application or claim and may be a basis for denying an application or claims for benefits.

IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

THE APPLICANT AND, IF APPLICABLE, THE EMPLOYER MUST SIGN AND DATE THIS FORM FOR ENROLLMENT.

APPLICANT SIGNATURE _____ DATE _____

EMPLOYER SIGNATURE (IF APPLICABLE) _____ DATE _____