SUMMACARE CHANGE FORM

TO BE COMPLETED BY THE EMPLOYER

SEND COMPLETED FORM TO ELIGIBILITY: FAX: 330-996-8953 EMAIL: EnrollmentACTs@summacare.com MAIL: PO BOX 3620 Akron, OH 44309

DATE RECEIVED BY EMPLOYER	GROUP NUMBER	DIVISION NUMBER	PLAN TYPE

EMPLOYEE CLASS
HOURLY SALARY FULL TIME COBRA RETIREE MEDICARE WRAP

TO BE COMPLETED BY THE EMPLOYEE RETURN TO YOUR BENEFITS OFFICE – DO NOT SEND DIRECTLY TO SUMMACARE

EMPLOYEE NAME (ON ORIGINAL APPLICATION)	CONTRACT NUMBER

EMPLOYEE INFORMATION CHANGE: ☐ ADDRESS ☐ MARITAL STATUS ☐ DIVISION CHANGE ☐ NAME CHANGE
NEW NAME:____

COMPLETE ONLY THE BOXES BELOW THAT ARE APPLICABLE TO YOUR CHANGE

ADDRESS NUMBER & STREET	CITY	STATE	ZIP CODE	COUNTY

HOME PHONE #	WORK PHONE #	EMAIL ADDRESS
( )	( ) EXT.	

MEMBER CHANGES – ADDITIONS, TERMINATIONS, CHANGES (up to 3 per form)

If adding a spouse due to marriage, attach a copy of the Marriage Certificate to prevent a delay in coverage.
If adding a spouse and/or dependents due to loss of coverage, please attach a copy of the HIPAA Certificate showing prior carrier coverage to prevent a delay in coverage.
If adding a dependent due to Court Order, attach a copy of the Order stating who is ordered by the Courts to provide principle support and medical care for the dependent(s) listed.
If adding an adult child between the ages of 19-28 additonal information may be requested in order to determine eligibility requirements per HealthCare Reform Regulations.

Name (last, first, MI)	SOCIAL SECURITY NUMBER	RELATIONSHIP	FULL TIME STUDENT Y/N	GENDER	DATE OF BIRTH (mo/day/yr)	DATE OF EVENT
MEMBER DIVISION NUMBER	**PCP # / FAMILY DOCTOR**			**Reason Codes (See Codes Below)**		**KEEP ON LIFE ONLY POLICY (EMPLOYEE ONLY)**
						☐ YES ☐ NO

Name (last, first, MI)	SOCIAL SECURITY NUMBER	RELATIONSHIP	FULL TIME STUDENT Y/N	GENDER	DATE OF BIRTH (mo/day/yr)	DATE OF EVENT
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						☐ YES ☐ NO

REASON CODES:
AM = Add Marriage AB = Add Birth AQ = Add Qualifying Event CN = Dependent Name Change CD = Dependent Division Change CP = Change PCP
CM = Change To Medicare Wrap Division DI = Term-Divorce DT = Term-Death TM = Involuntarily Term TV = Voluntarily Leaving The Plan
OT = Other REASON (describe): ____________________

HAVE YOU BEEN COVERED UNDER ANY OTHER HEALTH PLAN WITHIN THE LAST 12 MONTHS ☐ YES ☐ NO
IF YES, PLEASE PROVIDE A COPY OF THE CERTIFICATE OF CREDITABLE COVERAGE FROM YOUR PRIOR CARRIER

☐ CHECK HERE IF YOUR SPOUSE IS ELIGIBLE FOR COVERAGE THROUGH HIS/HER EMPLOYER

ARE YOU OR YOUR DEPENDENTS CURRENTLY COVERED BY OTHER HEALTH INSURANCE? ☐ NO ☐ YES If "yes" please complete the following information:

INSURANCE COMPANY NAME & ADDRESS	POLICY HOLDER NAME / DATE OF BIRTH	EFFECTIVE DATE OF POLICY	NAMES OF COVERED FAMILY MEMBERS	GROUP #	COVERAGE TYPE

Please indicate level of coverage:
☐ MEDICAL + RX ☐ MEDICAL ONLY ☐ VISION ☐ PHARMACY ONLY ☐ DENTAL ☐ OTHER____________________

MEDICARE ELIGIBILITY (Complete this section if you or your dependents are covered by Medicare Part A and/or B and D)

NAME OF COVERED PERSON	Medicare #	Indicate Coverage	Effective Date
		☐ Part A ☐ Part B ☐ Part D	Part A__________ Part B__________ Part D__________
		☐ Part A ☐ Part B ☐ Part D	Part A__________ Part B__________ Part D__________

EMPLOYEE____ DATE______________

TERMS AND CONDITIONS

a. I understand that I am responsible for reporting to my employer, within 31 days, any changes in my employee status, in the number of my eligible dependents, in my spouse's employer health coverage, or any change in my residence.

b. By signing this application, you and your spouse hereby authorize any hospital, physician, surgeon, pharmacist or other health care provider, any insurance company, any third-party administrator, or final payer of claims to release to and/or receive from SummaCare, third-party administrator, or appropriate other entity any information concerning claims or the delivery of medical care for yourself and your covered underage dependents. Employee and spouse understand that such information may be used to provide appropriate treatment, coordination of care, quality measurement and other appropriate uses related to treatment and care. Employee and spouse further understand that medical information may be obtained from the review of medical records and claims records that may contain information regarding behavioral health, HIV, Acquired Immune Deficiency Syndrome (AIDS), pharmacy and substance abuse. Employee and spouse acknowledge that signing this Enrollment Application provides authorization for the release of medical information as stated herein. Consent is effective for the term of your membership with SummaCare. Upon making changes to your enrollment status with SummaCare, you and or your spouse will be asked to submit a revised signed enrollment form. Doing so maintains current consent for release of medical information as stated above.

You have the right to approve the release of personal health information beyond the uses identified in this consent. Special consent is required to provide data requested for workers' compensation or auto insurance claims; any release of information that could result in you being contacted by another organization for marketing purposes; and research studies. In the event that you are deemed incompetent or cannot provide consent, SummaCare requires documented proof of power of attorney or guardianship prior to release of information. Legal counsel will review the documentation prior to release of information.

Any data shared with employer groups is not implicitly or explicitly member identifiable, unless the member involved provides specific consent. Self-Funded Employers requiring identifiable data are held to strict confidentiality standards that protect the data from internal disclosure for any use that would adversely affect members.

The release of information is personal to you and your underage dependents. You may not authorize release of personal health information for your spouse unless documented proof of power of attorney or guardianship is provided with the enrollment application. If your spouse is receiving health care coverage under this plan, he/she must sign the enrollment application authorizing the release of personal health information as stated above.

Personal health information may be released without your consent by order of a court with appropriate jurisdiction. SummaCare warrants that any other person and or/entity that receives information from SummaCare sign a confidentiality agreement which requires then to abide by and release information in accordance with SummaCare's confidentiality policies and procedures.

c. I agree that benefits payable on my account or my dependent's account under my employer's group medical benefits plan will be paid directly to the provider of care.

d. I understand that no benefits shall take effect until this application is approved for SummaCare participation. Upon acceptance, as soon as possible, a SummaCare identification card(s) will be issued to me as evidence of coverage hereunder. Upon termination all identification card(s) received must be destroyed.

e. If there is a payroll, disability or pension deduction for my enrollment in SummaCare, I authorize it to be made.

SummaCare Customer Service

330-996-8700
Out-of Area (800) 996-8701
P.O. Box 3620
Akron, Ohio 44309
www.summacare.com