



## Employer Enrollment Checklist

- Original Patriot Healthcare Employer Application for Group Insurance if electing medical coverage**
  
- Original Northeast Delta Dental Contract if electing Signature Plus Plans only**
  
- Original Genworth Financial Group Application if electing Genworth products**
  
- Wellness Program Forms if electing Wellness Program discount**  
(Must be submitted by the 15<sup>th</sup> of prior month to effect next month's premium)
  
- HRA Administrative Service Agreement (If applicable)**
  
- HSA Financial Institution Set up (If applicable)**
  
- Pre-Arranged Withdrawals Authorization** *(Required for Groups 1-10 )*
  
- Tax and Wage Report: Form C-2 or Schedule C** *(Required for Groups 20 and under)*
  
- Original Standardized Health Form** *(Required for Groups 1-50 ONLY)*
  
- 1<sup>st</sup> Month's Premium Binder Check**
  
- Member Enrollment Forms: Any outstanding forms should be faxed to Patriot Healthcare at (603) 296-0315**

<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		
		/ /					
		/ /					
				Contact Phone No. ( ) -			
Is your company a: <input type="checkbox"/>							
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>							
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>							
Rehire Policy:				Do you plan to offer coverage to domestic partners?		If yes, please select applicable eligibility type	
				<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>							
<input type="checkbox"/> <input type="checkbox"/>							
<input type="checkbox"/> <input type="checkbox"/>							
Please indicate the number of employees in your group in each of the following classifications as of today's date:							
(1) Employees on Payroll	(2) Eligible Employees	(3) Employees Enrolling in Plan	(4) Employees Covered through Spouse	(5) Total Employees Covered <b>(3) + (4)</b>	(6) Declined Coverage	(7) % of Participation <b>(5)÷(2)</b>	

Monthly Premium Rates for the period beginning _____		through _____			
	Employee Only	Employee & Spouse	Employee & Child(ren)	Family	
<input type="checkbox"/> Signature I**	\$	\$	\$	\$	
<input type="checkbox"/> Signature II**					
<input type="checkbox"/> Signature III**					
<input type="checkbox"/> Standard I	\$	\$	\$	\$	
<input type="checkbox"/> Standard II					

*These rates are effective for the period described above.*

COBRA administration is provided by Employee Benefit Plan Administration (EBPA) as a service to Patriot customers. If you **do not** want EBPA to provide COBRA administration services, please indicate your decision below. If you are not subject to COBRA, EBPA will administer the 39 week extension.

- I DO want EBPA to provide COBRA administration services  
 I DO NOT want EBPA to provide COBRA administration services

**Section 3 -- TO BE COMPLETED FOR GROUPS USING BROKER**

Agency Name and Address	Agency Phone	Agency Fax
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Broker Name

**Section 4 - TERMS AND CONDITIONS**

Coverage Provided: Patriot will provide group health coverage to eligible Members under the terms and conditions set out in the Member Certificate.

Premium: Monthly premium is due in advance from the Employer by the first of the effective month. The amount invoiced by Patriot shall reflect Membership as of the first day of the month. The Employer shall pay the invoiced amount even if Membership changes have occurred. Each month, premium will be adjusted reflecting membership changes that occurred in the preceding month.

Premium shall be paid by automatic electronic funds transfer unless another arrangement is agreed to in advance by Patriot. If payment is not received by the last day of the month, claims will be pended. If payment is not received by the 31st day, a termination notice will be mailed. If payment is not received by the 10<sup>th</sup> day of the following month, the group will be immediately terminated and Patriot will provide written notice of cancellation.

The rates quoted by Patriot shall remain in effect until the Anniversary Date, except that such rates may be increased by Patriot with at least 30 days notice to the Employer in the following cases: (i) the Employer and Patriot agree to a benefit change; (ii) there is a change in the law effecting Patriot's cost of providing coverage, including, but not limited to the addition of mandatory benefits or the imposition of a new tax or surcharge effective prior to the Employer's Anniversary Date.

Patriot shall provide Employer with a premium quote at least 60 days prior to the Anniversary date.

Employer's Termination Right: Employer has the right to terminate coverage under this Agreement with 30 days prior written notice to Patriot.

Employer's Participation in Member Education: The Employer agrees to participate in Patriot's member education by permitting employees to attend meetings and/or access Patriot's website from work at reasonable times as agreed in advance by Patriot and the Employer.

**I represent that all information contained in this application for group insurance is complete and correct to the best of my knowledge and belief. I understand that 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.**

**I acknowledge that the broker named above is the company's Broker of Record.**

**Section 5 - SIGNATURE**

Employer Signature _____	Patriot Healthcare _____
Print Name _____	Print Name _____
Title _____	Title _____
Date _____	Date _____

\*\*Same health rates apply to Signature **Plus** plans



**DELTA DENTAL PLAN OF NEW HAMPSHIRE, INC.  
PATRIOT HEALTHCARE SIGNATURE PLUS PLAN  
DENTAL CONTRACT APPLICATION**

Northeast Delta Dental  
One Delta Drive  
PO Box 2002  
Concord, NH 03302-2002  
800-537-1715  
www.nedelta.com

PLEASE TYPE OR PRINT LEGIBLY — IN BLUE OR BLACK INK ONLY

**GROUP NAME** \_\_\_\_\_ **GROUP # 19000 -** \_\_\_\_\_

	Plan I <input type="checkbox"/>	Plan II <input type="checkbox"/>
<b>Diagnostic and Preventive</b>		
<b>Diagnostic</b> Evaluations - once in a 6-month period; X-rays (Complete series or panoramic film) once in a 3-year period; Bitewing x-rays once in a 12-month period; X-rays of individual teeth as necessary  <b>Preventive</b> Cleanings four times in a 12-month period; Fluoride twice in a 12-month period to age 19; Space maintainers to age 16; Sealants for children to age 19 on permanent molars once in a 3-year period	Covered at 100%	Covered at 100%
<b>Deductible for Basic, Major, and Orthodontics</b>	\$250 per person/ \$750 per family per calendar year	\$500 per person/ \$1,500 per family per calendar year
<b>Basic</b>		
<b>Restorative</b> Amalgam (silver) fillings; Composite (white) fillings  <b>Oral Surgery</b> Surgical and routine extractions  <b>Endodontics</b> Root canal therapy  <b>Periodontics</b> Periodontal maintenance (cleaning): Cleanings four times in a 12-month period; this can be routine or periodontal, but not both  <b>Treatment of gum disease</b>  <b>Denture Repair</b> Repair of a removable denture to its original condition; Emergency palliative treatment	Covered at 100% after deductible	Covered at 100% after deductible
<b>Major</b>		
<b>Prosthodontics</b> Removable and fixed partial dentures (bridge); Complete dentures; Rebase and reline (dentures); Crowns; Onlays; Implants	Covered at 100% after deductible	Covered at 100% after deductible
<b>Orthodontics</b>		
<b>Orthodontics</b> Correction of crooked teeth for adults and children	Covered at 100% after deductible	Covered at 100% after deductible
	Employee Only Employee & Spouse Employee & Children Family	\$31.90 \$61.86 \$75.19 \$112.80
		\$19.08 \$36.22 \$49.50 \$71.99
<b>Benefit Maximum</b>	\$2,500 per person per calendar year	\$2,500 per person per calendar year

**Benefit percentages shown are based upon the actual charge submitted to a maximum of the Participating Dentist's approved fees, or Delta Dental's allowance for Nonparticipating Dentists.**

Name of Business: \_\_\_\_\_

By: **X** \_\_\_\_\_  
(Duly Authorized Signature)

By: \_\_\_\_\_

Name (please print): \_\_\_\_\_

Name: **Thomas Raffio**

Title: \_\_\_\_\_

Title: **President & CEO**

Date: \_\_\_\_\_

Date: \_\_\_\_\_



PRE-ARRANGED WITHDRAWALS AUTHORIZATION FORM

I hereby authorize Patriot Health Insurance Company, Inc. of Manchester New Hampshire, to initiate withdrawals each month for Premium Payments against the bank account of:

Bank Name: \_\_\_\_\_

Bank Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Bank Info: Routing #: \_\_\_\_\_ Account #: \_\_\_\_\_

Type of Account:  Checking  Savings

Monthly withdrawals are done on approximately the 1<sup>st</sup> of every month.

This authorization is to remain in effect until Patriot Health Insurance Company, Inc. is given 30 days written notice of termination.

Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Print Name: \_\_\_\_\_

Authorized Signer: \_\_\_\_\_ Date: \_\_\_\_\_



**SECTION 4 – (Continued)**

B. Are you or any person to be covered under this plan currently pregnant, undergoing fertility treatment or an expectant father?  
 Yes  No If yes, due date: \_\_\_\_\_  Single  Multiple Fetuses? (Please check one)

C. Have you or any person to be covered under this plan been advised to have medical treatment, testing, or surgery at some time in the future?  Yes  No

**SECTION 5 – MEDICAL DETAILS:** Provide complete details for all YES answers from Section 4. Additional details may be provided on a separate sheet (signed and dated).

Question (e.g. A.1)	Name of Individual	Diagnosis	Treatment and Dates of Treatment	Medication Prescribed	Surgery or Hospitalized?	Recovered?	Treating Physician
				<input type="checkbox"/> Yes <input type="checkbox"/> No Drug:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name: Phone:
				<input type="checkbox"/> Yes <input type="checkbox"/> No Drug:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name: Phone:
				<input type="checkbox"/> Yes <input type="checkbox"/> No Drug:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name: Phone:
				<input type="checkbox"/> Yes <input type="checkbox"/> No Drug:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name: Phone:
				<input type="checkbox"/> Yes <input type="checkbox"/> No Drug:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name: Phone:
				<input type="checkbox"/> Yes <input type="checkbox"/> No Drug:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name: Phone:

**SECTION 6 – STANDARDIZED HEALTH FORM CERTIFICATION:** I represent that all statements, answers and information I have given relating to me or my dependents is complete and correct to the best of my knowledge and belief. I understand that it is a crime to knowingly provide false, incomplete or misleading information to an insurance carrier for the purpose of defrauding the company. I also understand that the information I have given will be used by my health carrier and be the basis of reinsurance ceding decisions. I will not be denied coverage based on my health status nor will my premium rates be affected by my health status.

I/we understand that any physician, other healthcare practitioner, hospital or clinic providing treatment to me or any of the eligible dependents covered by this health statement may be contacted for additional healthcare information and I authorize such persons and entities to release medical records and medical information to my health carrier in order to accurately assess medical risk for reinsurance purposes pursuant to NHRSA 420-G:5,1. I understand that if I choose not to provide this release and information, my eligibility for coverage may be denied or enrollment may be delayed. I understand that I have the right to revoke this authorization in writing at any time. If I do revoke this authorization however, I understand the revocation may impact my eligibility or enrollment for coverage. This authorization shall be valid for 60 days from the date of my signing this Standardized Health Form below.

Employee Name (Printed)	Employee Signature	Date
Spouse Name (Printed)*	Spouse Signature	Date

\* if applicable

# MEMBER ENROLLMENT FORM



ALL INFORMATION MUST BE PROVIDED, PLEASE PRINT IN INK OR TYPE

SECTION 1: SUBSCRIBER INFORMATION		
NAME	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	EMPLOYER NAME
STREET ADDRESS	HOME PHONE WORK PHONE	DIVISION / SUB GROUP
CITY, STATE, ZIP CODE	SOCIAL SECURITY NO.	DATE OF HIRE
EMPLOYMENT STATUS :  <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/> RETIRED <input type="checkbox"/> COBRA  <input type="checkbox"/> SALARIED <input type="checkbox"/> IF HOURLY -# HOURS WORKED WKLY _____	MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED  <input type="checkbox"/> DIVORCED <input type="checkbox"/> LEGALLY SEPARATED  <input type="checkbox"/> DOMESTIC PARTNER	DATE OF BIRTH
		DATE COVERAGE EFFECTIVE

SECTION 2: ENROLLMENT CHOICES			
<b>WAIVING COVERAGE</b> (Check box that best describes situation resulting from coverage waiver):			
<input type="checkbox"/> I AM DECLINING ENROLLMENT, <b>I DO</b> HAVE COVERAGE THROUGH SPOUSE, OR ELSEWHERE <input type="checkbox"/> I AM DECLINING ENROLLMENT, <b>I DO NOT</b> HAVE COVERAGE ELSEWHERE			
<b>COVERAGE TYPE:</b> <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> EMPLOYEE & SPOUSE <input type="checkbox"/> EMPLOYEE & CHILD <input type="checkbox"/> FAMILY  <b>PLAN TYPE:</b> <b>SIGNATURE PLANS:</b> <b>SIGNATURE PLUS PLAN: (DENTAL OPTION)</b> <b>STANDARD PLANS :</b>			
DEDUCTIBLE I: <input type="checkbox"/> \$1,200/\$2,400	DEDUCTIBLE I: <input type="checkbox"/> \$1,200/\$2,400	DEDUCTIBLE I: <input type="checkbox"/> \$500/\$1000	
DEDUCTIBLE II: <input type="checkbox"/> \$2,500/\$5,000	DEDUCTIBLE II: <input type="checkbox"/> \$2,500/\$5,000	DEDUCTIBLE II: <input type="checkbox"/> \$1000/\$2,000	
DEDUCTIBLE III: <input type="checkbox"/> \$5,000/\$10,000	DEDUCTIBLE III: <input type="checkbox"/> \$5,000/\$10,000		

SECTION 3: DEPENDENT INFORMATION					
DEPENDENT NAME (Last, First, MI)	NAME OF PCP	RELATIONSHIP	DATE OF BIRTH	GENDER	STATUS
		<input type="checkbox"/> SPOUSE			<input type="checkbox"/> DATE OF MARRIAGE <input type="checkbox"/> DATE OF DIVORCE
		<input type="checkbox"/> CHILD <input type="checkbox"/> STEP-CHILD			<input type="checkbox"/> FULL-TIME STUDENT <input type="checkbox"/> HANDICAPPED/DISABLED
		<input type="checkbox"/> CHILD <input type="checkbox"/> STEP-CHILD			<input type="checkbox"/> FULL-TIME STUDENT <input type="checkbox"/> HANDICAPPED/DISABLED
		<input type="checkbox"/> CHILD <input type="checkbox"/> STEP-CHILD			<input type="checkbox"/> FULL-TIME STUDENT <input type="checkbox"/> HANDICAPPED/DISABLED
		<input type="checkbox"/> CHILD <input type="checkbox"/> STEP-CHILD			<input type="checkbox"/> FULL-TIME STUDENT <input type="checkbox"/> HANDICAPPED/DISABLED

Who is legally responsible for stepchildren's medical bills? \_\_\_\_\_  
 For dependents over 19, you must provide name of school and expected graduation date: \_\_\_\_\_

SECTION 4: SPOUSE EMPLOYER INFORMATION:	
If spouse is employed, give Name and Address of employer: _____	
Does spouse's employer offer medical or dental coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO	

SECTION 5: OTHER INSURANCE					
Are you and/or your dependents covered under another health or dental insurance plan (including Medicare or Medicaid)? <input type="checkbox"/> YES <input type="checkbox"/> NO					
If yes, please provide the following information and attach a copy of the plan's ID card in order to assure accurate and timely processing of your claims.					
HEALTH INSURANCE CO. NAME & ADDRESS			DENTAL INSURANCE CO. NAME & ADDRESS		
POLICYHOLDER NAME	POLICY NUMBER	GROUP POLICY	POLICYHOLDER NAME	POLICY NUMBER	GROUP NUMBER
EFFECTIVE DATE	TYPE OF COVERAGE <input type="checkbox"/> SINGLE <input type="checkbox"/> 2 PERSON <input type="checkbox"/> FAMILY		EFFECTIVE DATE	TYPE OF COVERAGE <input type="checkbox"/> SINGLE <input type="checkbox"/> 2 PERSON <input type="checkbox"/> FAMILY	

SECTION 6: HIPAA COMPLIANCE	
Will this plan replace existing health insurance coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, please attach to this form a certificate of prior health insurance coverage. Your prior insurer will give you this form.

SECTION 7: SIGNATURE	
I represent that the statements on this benefit enrollment and change form and all information furnished by me are true and complete to the best of my knowledge. I authorize any healthcare provider to disclose to Patriot Health Insurance Company Inc., or its designated agent, any information acquired in connection with my past or future care or treatment or that of any dependent named herein or hereafter added to my coverage.	
Subscriber's Signature	Date