Member Application (EverydayCARE™)

Redirect Health®

Member Information (all information must be completed to ensure coverage)

Employer Name:	Date Employed:	☐ Part-Time	☐ Full-Time
Last Name:	First Name:	MI:	
Date of Birth:	Gender:	Height:	Weight:
Social Security Number:	Marital Status:		
Address:			
City:	State:	Zip:	
Phone:	Email:		

Choose Your Plan

- ☐ EverydayCARE™ (no hospitalization with plan)
- ☐ EverydayCARE™ + Medical Cost Share
- ☐ EverydayCARE™ Plus 30
- ☐ EverydayCARE™ Plus 50
- ☐ EverydayCARE™ Plus 125
- ☐ EverydayCARE™ Plus 200

Choose Your Coverage

- ☐ Individual only
- ☐ Individual & child(ren)
- ☐ Individual & spouse
- ☐ Family

Family Information (if choosing individual & child(ren), individual & spouse, or family plan)

First Name & Middle Initial (Last Name if Different)	Date of Birth	Gender	Height	Weight	Social Security #	Full Time Student	
Spouse:						☐ Yes	☐ No
Child:						☐ Yes	☐ No
Child:						☐ Yes	☐ No
Child:						☐ Yes	☐ No
Child:						☐ Yes	☐ No

Beneficiary Information (person who receives benefits in the case of your death - you are the beneficiary for dependents)

Last Name:	First Name:	MI:
Gender:	Relationship to You:	

Make Changes to Your Current Plan

If changing plans, indicate qualifying event:	☐ Marriage	☐ Divorce	☐ Returning to School Full-Time
	☐ Adoption	☐ Court Order	☐ Other (Specify):
Date of Qualifying Event:		You may be required to provide proof of event	

Member Agreement (signature required)

I authorize my employer to deduct the necessary contributions toward the benefits I have selected on a pre-tax basis from my pay. I understand that I cannot change the benefits I have selected or revoke this pay deduction authorization before the beginning of the next plan year unless that change or revocation is made on account of, and corresponds with, a change in status, a special enrollment event, or any other event that permits a mid-year change or revocation of elections under the terms of my employer's Section 125 cafeteria plan.

Fraud Warning Notices: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act, which is a crime. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the enrollee or Insured Person.

Employee Signature:	Date:
If signed by a representative of enrollee, please indicate the representative's authority to act on behalf of enrollee	

➥ Waiver on Back

Waiver (only complete this section if you are waiving all coverage)

I am declining coverage for (check all that apply): ☐ Individual ☐ Spouse ☐ Child(ren)

I am declining coverage for the following reason(s):

(Check all that apply and note that if you are declining coverage because you have other coverage, you must indicate that on this form. Failure to do so may result in you not being able to exercise special enrollment rights if you lose other coverage)

☐ Covered by a spouse's group health plan ☐ Individual medical plan ☐ Not affordable ☐ COBRA/State Continuation

☐ Government Plan (please specify plan name):

☐ Other reason:

I understand that this waiver is reported to IRS informing them I have declined the Employer-provided healthcare plan and this may result in fines and repayment of any federal subsidies when selecting insurance through the online network. If I have waived coverage for myself and/or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself and/or my dependents in the coverage, provided that I request enrollment within 31 days (60 days for losses of Medicaid or state Children's Health Insurance Program (CHIP) coverage) after my other coverage ends because of involuntary loss of eligibility (such as divorce, death, legal separation, termination of employment, reduction in number of hours of employment, or exhaustion of the full COBRA coverage period). In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll my dependents, provided that I request enrollment within 31 days after the date of the event. In addition, if I or my dependents become eligible for state premium assistance subsidies through Medicaid or state CHIP coverage, I may in the future be able to enroll myself and/or my dependents in the coverage, provided that I request enrollment within 60 days after such eligibility is determined.

Employee Signature:	Date:

If signed by a representative of enrollee, please indicate the representative's authority to act on behalf of enrollee