TEAMCARE® ENROLLMENT FORM

Healthcare coverage for your family members will not begin until we receive a completed ***TeamCare Enrollment Form***. Please select a Coverage Level, then complete the sections specified. It is your responsibility to sign and return this form to the Inframark Benefits Department at benefits@inframark.com along with any applicable documents required by the ***Documents Required for Enrollment*** notice.

Please select **one** Coverage Level:

☐ **Member (Employee) Only** Complete Sections **1 & 4**

☐ **Member + Spouse** Complete Sections **1, 2 & 4**

☐ **Member + Children** Complete Sections **1, 2, 3 & 4**

☐ **Family** Complete Sections **1, 2, 3 & 4**

SECTION 1	**EMPLOYEE INFORMATION**	*** See *Documents Required for Enrollment* insert ***
EMPLOYER NAME:	LOCAL UNION:	DATE OF HIRE:
SOCIAL SECURITY NO.: (required by Federal law)	TEAMCARE ID NUMBER: **806** __ __ __ __ __ __	BIRTH DATE:
LAST NAME:	FIRST NAME, MIDDLE INITIAL:	
ADDRESS:		
CITY, STATE & ZIP:		
PHONE NUMBER:	E-MAIL ADDRESS:	
MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED		☐ MALE ☐ FEMALE

SECTION 2	**SPOUSE INFORMATION**	*** See *Documents Required for Enrollment* insert ***
IMPORTANT: Spouse information is required for Coordination of Benefits purposes even if spouse coverage is not elected.		
SPOUSE'S SOC. SEC. NO.: (required by Federal law)	BIRTH DATE:	☐ MALE ☐ FEMALE
LAST NAME:	FIRST NAME, MIDDLE INITIAL:	MARRIAGE DATE:
SPOUSE'S EMPLOYER:	EMPLOYER PHONE:	MARRIAGE LOCATION (CITY/STATE):
DOES YOUR SPOUSE HAVE INSURANCE THROUGH HIS/HER EMPLOYER? ☐ YES ☐ NO ☐ NOT EMPLOYED		
CHECK **ALL** THE COVERAGES PROVIDED BY SPOUSE'S INSURANCE: ☐ MEDICAL ☐ RX ☐ DENTAL ☐ VISION ☐ MEDICARE ☐ MEDICAID		
DOES YOUR SPOUSE'S INSURANCE PROVIDE COVERAGE FOR CHILDREN? ☐ YES ☐ NO		
NAME OF INSURANCE CARRIER:	CARRIER PHONE:	
GROUP POLICY NUMBER:	EFFECTIVE DATE:	

SECTION 3	**CHILDREN INFORMATION**	*** See *Documents Required for Enrollment* insert ***

CHILD #1

LAST NAME	FIRST NAME & MIDDLE INITIAL	BIRTH DATE	SOCIAL SEC. NO. (required by Federal law)	GENDER	RELATIONSHIP TO EMPLOYEE
				☐ M ☐ F	

DOES THIS CHILD HAVE OTHER INSURANCE COVERAGE? ☐ YES ☐ NO		
IF YES, CHECK **ALL** THE COVERAGES AVAILABLE FOR THIS CHILD: ☐ MEDICAL ☐ RX ☐ DENTAL ☐ VISION ☐ MEDICARE ☐ MEDICAID		
POLICYHOLDER NAME:	RELATIONSHIP TO CHILD:	EFFECTIVE DATE:
NAME OF INSURANCE CARRIER:	GROUP POLICY NUMBER:	CARRIER PHONE:

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SECTION 3 CHILDREN INFORMATION continued * See *Documents Required for Enrollment* insert *

CHILD #2

LAST NAME	FIRST NAME & MIDDLE INITIAL	BIRTH DATE	SOCIAL SEC. NO. (required by Federal law)	GENDER	RELATIONSHIP TO EMPLOYEE
				☐ M ☐ F	

DOES THIS CHILD HAVE OTHER INSURANCE COVERAGE? ☐ YES ☐ NO

IF YES, CHECK **ALL** THE COVERAGES AVAILABLE FOR THIS CHILD: ☐ MEDICAL ☐ RX ☐ DENTAL ☐ VISION ☐ MEDICARE ☐ MEDICAID

POLICYHOLDER NAME:	RELATIONSHIP TO CHILD:	EFFECTIVE DATE:
NAME OF INSURANCE CARRIER:	GROUP POLICY NUMBER:	CARRIER PHONE:

CHILD #3

LAST NAME	FIRST NAME & MIDDLE INITIAL	BIRTH DATE	SOCIAL SEC. NO. (required by Federal law)	GENDER	RELATIONSHIP TO EMPLOYEE
				☐ M ☐ F	

DOES THIS CHILD HAVE OTHER INSURANCE COVERAGE? ☐ YES ☐ NO

IF YES, CHECK **ALL** THE COVERAGES AVAILABLE FOR THIS CHILD: ☐ MEDICAL ☐ RX ☐ DENTAL ☐ VISION ☐ MEDICARE ☐ MEDICAID

POLICYHOLDER NAME:	RELATIONSHIP TO CHILD:	EFFECTIVE DATE:
NAME OF INSURANCE CARRIER:	GROUP POLICY NUMBER:	CARRIER PHONE:

CHILD #4

LAST NAME	FIRST NAME & MIDDLE INITIAL	BIRTH DATE	SOCIAL SEC. NO. (required by Federal law)	GENDER	RELATIONSHIP TO EMPLOYEE
				☐ M ☐ F	

DOES THIS CHILD HAVE OTHER INSURANCE COVERAGE? ☐ YES ☐ NO

IF YES, CHECK **ALL** THE COVERAGES AVAILABLE FOR THIS CHILD: ☐ MEDICAL ☐ RX ☐ DENTAL ☐ VISION ☐ MEDICARE ☐ MEDICAID

POLICYHOLDER NAME:	RELATIONSHIP TO CHILD:	EFFECTIVE DATE:
NAME OF INSURANCE CARRIER:	GROUP POLICY NUMBER:	CARRIER PHONE:

CHILD #5

LAST NAME	FIRST NAME & MIDDLE INITIAL	BIRTH DATE	SOCIAL SEC. NO. (required by Federal law)	GENDER	RELATIONSHIP TO EMPLOYEE
				☐ M ☐ F	

DOES THIS CHILD HAVE OTHER INSURANCE COVERAGE? ☐ YES ☐ NO

IF YES, CHECK **ALL** THE COVERAGES AVAILABLE FOR THIS CHILD: ☐ MEDICAL ☐ RX ☐ DENTAL ☐ VISION ☐ MEDICARE ☐ MEDICAID

POLICYHOLDER NAME:	RELATIONSHIP TO CHILD:	EFFECTIVE DATE:
NAME OF INSURANCE CARRIER:	GROUP POLICY NUMBER:	CARRIER PHONE:

Please supply information for additional children on a separate sheet.

SECTION 4 MEMBER CERTIFICATION REQUIRED

I have read the ***Enrollment Rules for Multi-Tiered Plans*** and understand that changes in my coverage can only be made in accordance with those guidelines. I certify the accuracy of this information and understand that I must inform TeamCare of any changes.

Member Name (print) **SSN or TeamCare ID No.**

Member Signature **Date**

FOR OFFICE USE ONLY

TEAMCARE®
A CENTRAL STATES HEALTH PLAN

DOCUMENTS REQUIRED FOR ENROLLMENT

Please provide us with copies of the applicable documentation as outlined below.

To properly enroll you and your dependents, the following information and/or documentation is required. When electing coverage for your dependents, the Plan requires that the dependent meets the necessary requirements to be enrolled. By law, Social Security Numbers (SSNs) are required for each individual covered by TeamCare.

ENROLLING ONLY THE EMPLOYEE:

Complete *Employee Information* section on the *TeamCare Enrollment Form*. **You must include your Social Security Number**.

ENROLLING EMPLOYEE AND SPOUSE (if applicable):

Complete *Employee and Spouse Information* sections on the *TeamCare Enrollment Form* and **include SSNs for both you and your spouse. Claims cannot be paid until this information is given.** In certain cases, a marriage certificate may be required.

ENROLLING ONE OR MORE CHILDREN (if applicable):

Complete *Employee, Spouse and Children Information* sections and **include SSNs for all individuals**. Also, include copies of the following documents, if applicable:

IMPORTANT: Spouse information is required for Coordination of Benefits purposes **even if spouse coverage is not elected.**

Dependent Child from a Previous Marriage

- ☐ The complete Divorce Decree & Settlement of the natural parents
- ☐ Name and birth date of natural parents, including information regarding any other insurance coverage

Stepchild

- ☐ Birth Certificate of child or the complete Divorce Decree & Settlement of the natural parents
- ☐ Marriage Certificate to current spouse
- ☐ Name and birth date of natural parents, including information regarding any other insurance coverage

Child Born Outside of Marriage

- ☐ Court Order regarding insurance
- ☐ Birth Certificate of child
- ☐ Name and birth date of other natural parents, including information regarding any other insurance coverage

Child for Which You are Guardian

- ☐ Guardianship / Custody documents

Adopted Child

- ☐ Final Adoption Papers
- ☐ If the adoption is not yet final, please provide a copy of the Placement Agreement

Adult Child

- ☐ Birth Certificate of the child

To return the *Enrollment Form* to the Inframark Benefits Department, there are two ways to do it:

MAIL	 E-mail the completed *Enrollment Form* a and required documents to: **Benefits@inframark.com**	**FAX**	 Fax the *Enrollment Form* and required documents to: **215-392-3336**

TEAMCARE®
A CENTRAL STATES HEALTH PLAN

ENROLLMENT RULES FOR MULTI-TIERED PLANS

Your Coverage Level election on your *TeamCare Enrollment Form* is binding and may be changed only during the annual Open Enrollment period, or within 60 days of a Special Enrollment event as described below. It is extremely important that you notify TeamCare whenever you have a change in your family situation.

OPEN ENROLLMENT

Open Enrollment begins in early November each year, during which you may elect to change your dependent Coverage Level for any reason. Information and instructions to change your dependent Coverage Level will be mailed to you. During Open Enrollment, any dependent coverage change will become effective at the start of the next plan year and will remain in effect until changed by you due to a Special Enrollment event or during a subsequent Open Enrollment. It is important to note that if your spouse or adult child voluntarily discontinues coverage through their employer, a change to your dependent Coverage Level will be allowed only during Open Enrollment.

SPECIAL ENROLLMENT

In addition to the annual Open Enrollment period, you may change your dependent Coverage Level if you or a family member has a Special Enrollment event as indicated below:

1. **Loss of Other Insurance Coverage**

   You may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 60 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

2. **Change in Dependents**

   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. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, please contact TeamCare through the Message Center at MyTeamCare.org or call 800-TEAMCARE (832-6227). When requesting special enrollment, please submit appropriate supporting documents (marriage license, birth certificate, etc.). If additional information is required to complete the enrollment, TeamCare will contact you for further details.