# PREVENTIVE CARE HEALTH PLAN APPLICATION

| EMPLOYEE INFORMATION | |
|---|---|
| Full Name | |
| Employee Number | |

| COVERAGE LEVEL & COST PER PAY PERIOD – SELECT ONE | | |
|---|---|---|
| Employee Only | $43.53 | ☐ |
| Employee + Child | $67.48 | ☐ |
| Employee + Spouse/Partner | $95.78 | ☐ |
| Employee + Family | $143.67 | ☐ |

## *PARTICIPANTS TO BE COVERED

Please complete information below for each of your dependents you wish you enroll in the plan. If needed, use the next page for additional dependents. *You are required to submit documentation to support eligibility for all dependents listed below. This includes marriage certificate/birth certificate and social security cards. Documentation must be submitted within 14 days of enrollment.

| | | | |
|---|---|---|---|
| Full Name | | Social Security Number | |
| Date of Birth | | Sex | |
| Relationship | | | |
| Full Name | | Social Security Number | |
| Date of Birth | | Sex | |
| Relationship | | | |
| Full Name | | Social Security Number | |
| Date of Birth | | Sex | |
| Relationship | | | |

## DISCLAIMER AND SIGNATURE

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of felony of the third degree. Any intent to provide false information and commit fraud may lead to corrective action and/or termination of employment.

By enrolling in this plan, I understand that this is a preventive care plan that does not cover medical expenses when I am sick, such as outpatient surgeries, emergency room visits or hospitalizations. I understand that I may be eligible for coverage and subsidies through the Federal Healthcare Exchange, Medicaid or other programs which provide comprehensive healthcare coverage.

I authorize Broward Health to deduct my premiums from my earnings. I understand that my coverage is dependent upon payment of premiums and remaining in an eligible status. I also authorize anyone providing services to me or my dependents to release any information or medical records relating to those services for treatment, payments and healthcare operations to Broward Health and its Third Party Administrator (TPA). All the information in this application is accurate and complete to the best of my knowledge.

Signature Date

| *ADDITIONAL DEPENDENT LISTING | | | |
|---|---|---|---|
| Use this page to add additional dependents not listed on page one. | | | |
| Full Name | | Social Security Number | |
| Date of Birth | | Sex | |
| Relationship | | | |
| Full Name | | Social Security Number | |
| Date of Birth | | Sex | |
| Relationship | | | |
| Full Name | | Social Security Number | |
| Date of Birth | | Sex | |
| Relationship | | | |
| Full Name | | Social Security Number | |
| Date of Birth | | Sex | |
| Relationship | | | |
| Full Name | | Social Security Number | |
| Date of Birth | | Sex | |
| Relationship | | | |