Attn: Employers

Subj: Employee/Dependent Add-Ons during plan year

Listed below are the requirements to add employees/dependents to your plan; the following documentation must be provided;

- Employee: Subscriber application (ensure the appropriate box on the application has been checked, must be within 90 days of hire or within 60 days of a Qualifying Event), two most recent payroll stubs, Michigan ID with photo, proof of loss of coverage include Certificate of Credible Coverage if not a new hire.
- Dependent: Subscriber application (ensure the appropriate box on the application has been checked, must be within 60 days of Qualifying Event) include Certificate of Credible Coverage.
- Spouse: Subscriber application (ensure the appropriate box on the application has been checked, must be within 60 days of Qualifying Event) include a copy of the marriage certificate or proof of loss of coverage (Certificate of Credible Coverage)
- Newborns Subscriber application (ensure the appropriate box on the application has been checked, must be within 60 days of Qualifying Event), recommend submission of application as soon as possible, include birth certificate. Child will be added on for coverage and charged a premium for the month in which they were born.

Also please don't forget to ensure the applications are submitted with the right premium!!!

These guidelines will be strictly enforced, including employment verification

Respectfully
Community Care Associates Member Services

** A QUALIFYING EVENT is an event that triggers an open enrollment window for an individual or family to purchase health insurance outside of the scheduled open enrollment periods. Includes the birth or adoption of a child, marriage or divorce, or the loss of other coverage.

rev/1/5/2021gj

HEALTHCHOICE of Michigan

COMPREHENSIVE GROUP MEDICAL PLAN

AVAILABLE TO ALL SMALL BUSINESSES LOCATED IN

WAYNE & OAKLAND COUNTY

- **NO DEDUCTIBLES OR COINSURANCE!!!**
- **PREVENTATIVE EXAMS COVERED IN FULL!!!**
- **$20.00 OFFICE COPAY $10/20 PRESCRIPTION COPAY!!!**
- **ONE STANDARD RATE REGARDLESS OF AGE OR GENDER!!!**

2024 Rates

Enrollment Category	Monthly Rate	Dental Rider	Vision Rider	Total
Employee Only	$254.16	$12.90	$2.60	$269.66
Employee & Spouse	$589.29	$25.89	$5.67	$620.85
Employee & 1 Dependent	$401.46	$21.93	$3.95	$427.34
Employee & 2 Dependents	$534.46	$28.40	$4.97	$567.83
Employee, Spouse & 1 Dependent or Employee & 3 Family Members	$802.72	$34.88	$7.62	$845.22
Employee & 4 or more Family Members	$1039.86	$41.35	$7.62	$1088.83

View Provider Directory

Go to www.ccarei.com Click on the Members Tab; you have two (2) options:

- **Find a Doctor: provides search fields to assist in locating by name, physician specialty, provider hospital affiliation or location specific.**
- **Provider Directory: the ability of viewing/printing a complete Provider Directory.**

FOR FURTHER INFORMATION: CONTACT YOUR SALES REPRESENTATIVE OR CALL: 313-961-3100 Ext. 734
OR VISIT OUR WEBSITE: WWW.CCAREI.COM

Subscriber Application Form
HealthChoice of Michigan
500 Griswold, 15th Floor
Detroit, MI 48226

GROUP #_____

PRINT CLEARLY

Last Name:	First Name:	Middle Initial	Phone Number ( )	Circle One: New ☐ Change ☐ Term ☐
Social Security #	Date of Birth	Sex	Date of Hire	
Home Address:	City	County	State	Zip Code
Do you have other medical insurance coverage? ☐ Yes or ☐ No	If Yes, Insurance Name:	Policy #		
Email address:				

List the names of each eligible dependents to be covered (see reverse side for dependent criteria)

1	Last Name:	First Name:		Middle Initial	Birth Date
Social Security #	Sex	Relationship	Age	Does dependent have other medical insurance coverage? ☐ Y or ☐ N	If yes, Insurance Name:
2	Last Name:	First Name:		Middle Initial	Birth Date
Social Security #	Sex	Relationship	Age	Does dependent have other medical insurance coverage? ☐ Y or ☐ N	If yes, Insurance Name:
3	Last Name:	First Name:		Middle Initial	Birth Date
Social Security #	Sex	Relationship	Age	Does dependent have other medical insurance coverage? ☐ Y or ☐ N	If yes, Insurance Name:

Dependent change only: Date of event: _____ Circle One: Marriage ☐ Newborn ☐ Principle Support ☐ Adoption/Legal Guardianship ☐

Deletion (Date of event) _____
Circle one: ☐ Divorce ☐ Death ☐ Other _____

By signing below, I acknowledge that I have been provided with at copy of this form, read understand and agree to the conditions listed and attached my most recent pay stub.

Applicant's Signature_____ Date_____

Company Name:		
Address:	City	Zip Code
Phone:		
Federal Tax Id:		

The undersigned represents and warrants that he/she has been authorized to execute this subscriber application and make the foregoing certifications on behalf of the employer, has been provided a copy and has read, understands and agrees to the conditions on the reverse side of this form.

Employer's Signature_____ Date_____

Subscriber Id# _____

Phone: 1-800-935-5669
Fax: 313-967-6386

Effective Date: _____

SUBSCRIBER CERTIFICATION OF ELIGILIBITY

By submission of this Subscriber Application, I am applying for Basic Services specified in my Subscriber Certificate of Eligibility with HealthChoice of Michigan and any amendments thereto (hereinafter collectively referred to as 'Subscriber Certificate') and for the selected Supplemental Services (also known as 'riders'), as defined in my Subscriber Certificate of Eligibility with HealthChoice of Michigan.

I understand that all Supplemental Services elected have been elected for me and all eligible dependents as defined in the Subscriber Certificate, and that I am responsible for paying my portion, an amount agreed upon with my employer, of the premium for the Supplemental Services in addition to the premium for Basic Services.

By submission of the Subscriber Application, I herby certify that, to the best of my knowledge, I qualify as a Subscriber under the terms of the Subscriber Certificate by meeting all the following criteria:

A. I am an employee of a qualified employer or a member of a qualified association and have an anticipated work future of more than five (5) months.
B. I am currently without health care benefits and am not eligible, without regard to the availability of coverage, for Medicare, Medicaid or other employer sponsored health coverage.
C. I am currently working at least 20 hours per week. I agree to notify HealthChoice if my hours are reduced to less than 20 hours per week for any reason at any time after enrollment.
D. My employer has not offered or contributed to health care benefits of employees in the same or similar job classification in which I am employed in the 65 day period immediately preceding the effective date of the Group Operating Agreement between my employer and HealthChoice of Michigan.
E. I am a resident of the State of Michigan as defined in the Subscriber Certificate, and I have accurately listed the County of my residence.
F. I have completed and signed this Subscriber Application for enrollment.

By submission of this Subscriber application for an eligible dependent as defined in the Subscriber Certificate, I hereby certify that, to the best of my knowledge, each eligible dependent listed on this application qualifies as an eligible dependent under the terms of the Subscriber Certificate by meeting all of the following criteria:

A. Be my spouse (Family Income is not exceeded), OR
B. Be a child of the Subscriber, which is defined as a son, daughter, stepson, stepdaughter, eligible foster child, or adopted child of the Subscriber until the child reaches the age of 26. An eligible foster child is an individual who is placed with the Subscriber by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction. An adopted child includes both a legally adopted child of the Subscriber and a child who is lawfully placed with the Subscriber for legal adoption by the Subscriber.
C. Not serving in the United States Armed Forces.
D. Be without health care benefits and not be eligible for any other health care program at time of enrollment.

By submission of this subscriber Application to my employer, I hereby authorize my employer to deduct from my wages, as a payroll deduction, an amount not to exceed that portion of the monthly advance premium and any Supplemental Services selected for myself and eligible dependents that my employer may charge to me under the terms of the subscriber Certificate of Eligibility.

I further certify that I have received and read the Subscriber Certificate, and I acknowledge that I have been advised that the Subscriber Certificate of Eligibility is available online at www.waynecounty.com/hhs/HealthChoice.htm I understand that the subscriber certificate, any riders thereto and this Subscriber Application Form contain the specific provisions and limitations of my coverage and are my contract with HealthChoice of Michigan.

I appoint my employer as my agent to handle all matters of HealthChoice of Michigan coverage. I am responsible for giving notices of changes in my status and that of my family members, which affect coverage, to my employer. I authorize HealthChoice of Michigan to obtain hospital and medical records relating to me and my family from providers of service.

HealthChoice or its Managed Care Providers may require any person to verify their ineligibility for Medicaid or Medicare by completion and submission of an application for Medicaid or Medicare benefits as a part of the Subscriber Application for the person or at any time during the period a person is a Member. **Refusal by a Member of request by the Program or its Managed Care Providers to complete and submit an application for Medicaid or Medicare benefits may result in termination of this Subscriber Certificate for the Member.**

I represent and warrant that the information provided by me on this Subscriber Application is true, correct and complete. I understand that if I falsify or withhold information requested by HealthChoice on the Subscriber Application, or as required under the Subscriber Certificate, including a refusal of a request by HealthChoice or its Managed Care Providers, I will be terminated from the Program immediately and coverage for myself and my eligible dependents will end as of the effective date of termination

EMPLOYER CERTIFICATION

By execution of and submission of this Subscriber Application, the undersigned certifies, on behalf of the employer, that to the best of the employer's knowledge, the applicant qualifies as a Subscriber under the terms of the Subscriber Certificate, that all eligible dependents for whom coverage is sought by the Subscriber qualify as eligible dependents under the terms of the Subscriber Certificate and that the employer qualifies as a Group whose employees may enroll as Subscribers under the terms of the Subscriber Certificate by meeting the following criteria unless waived in writing by HealthChoice.

A. Have their principle place of business for global operations located in Wayne or Oakland County.
B. At the time the Group enters into the Group Operating Agreement, the Group has two (2) or more employees that work full-time (30 hours or more weekly) who are otherwise eligible to enroll as Subscribers.
C. Including this Subscriber Application, the employer has submitted two (2) or more complete Subscriber Application for employees who otherwise qualify as Subscribers and will have two (2) or more employees enrolled in the program.
D. That 75% of full-time eligible employees are participating in the Plan.
E. At the time the Group enters into the Group Operating Agreement, not less than 50% of all employees have an hourly wage of fourteen dollars and fifty cents ($14.50) or less.
F. The employer has entered into a Group Operating Agreement with HealthChoice of Michigan.
G. Has provided verification of the legal existence of their business and list of employees.

If this form is being submitted for purposes of a Subscriber Change Form relating to COBRA coverage, employer certifies that it is responsible for determining the employee's eligibility for COBRA coverage and sending out all required COBRA notifications. Employer agrees to indemnify and hold harmless HealthChoice of Michigan related to COBRA eligibility, notification and coverage.

HealthChoice Plan of Michigan

Community Care Associates, Inc.
Primary Care Physician Selection & Health Assessment

Please Choose a Primary Care Physician for you and each family member being covered. If a Primary Care Physician is not chosen, one will be assigned to you nearest to your work or residence. You may change your Physician by contacting Community Care Associates at or 313-961-3100. This change will not take effect until prior approval by Community Care Associates and will generally take effect the 1st of the following month unless otherwise notified.

Employee Name:
Physician:

Spouse & Dependents

Name:
Physician:
Name
Physician:
Name
Physician:
Name
Physician:

To better manage your health care coverage: please provide the following information, this info will have no bearing on your eligibility or rates, it will simply assist in providing any medical care or case management in regards to you or your dependents (if any) medical condition.

Please indicate whether you/or any of your dependents have been treated or are being treated or received medical advice from any physician within the last 12 months. If yes, please provide basic information:

List name of individual and brief description:

_____

_____

_____

Current medication(s)?

_____

_____

_____

Signature_____ Date: _____

Print Name:_____

Gsj/cca/012016

HEALTHCHOICE of Michigan

Employee Add On Payment Authorization Form

Company Name: _____
Group #:_____
Street Address: _____
City, State, Zip Code: _____
Phone Number: _____

This form authorizes a one-time payment for adding a new employee/s on to your existing group plan, the amount will be deducted from your bank account, or charged to your Visa, MasterCard, American Express or Discover Card.

Please complete the information below:

I _____ authorize HealthChoice of Michigan to charge my credit card
(full name)

indicated for $_____.
(insert $)

Billing Address _____ Phone#_____

City, State, Zip _____ Email _____

Checking/ Savings Account

☐ Checking ☐ Savings

Name on Acct _____

Bank Name _____

Bank City/State _____

Submit a voided check or copy

**an additional .75% usage fee will apply

Credit Card

☐ Visa ☐ MasterCard

☐ Amex ☐ Discover

Cardholder Name _____

Account Number _____

Exp. Date _____

CVV (3 digit number on back of card)_____

*an additional 3% usage fee will apply

SIGNATURE _____ DATE _____

I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non Sufficient Funds (NSF) I understand that HealthChoice will contact me for an alternative payment and an additional $10 charge will be included. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.