Pace University Medical Plan Enrollment/NY Young Adult Option

Check all that apply: ☐ New Enrollment ☐ Qualifying Event ☐ Termination

Primary Insured

Social Security No.	Last Name	First Name & Middle Initial

Full time Date of Hire*	Home Address	City	State	Zip Code

Work Phone #*	Home Phone #	Birthdate	Gender	Marital Status	Employment Status
			☐Female ☐Male	☐Single ☐Married ☐ Divorced ☐ Domestic Partner	☐ Active ☐ Retiree ☐ LTD

*Only Complete if currently employed at Pace University

Health Care Enrollment

I am choosing medical coverage for:

☐ Individual ☐ I am Terminating Young Adult Option Medical Coverage

Medical Coverage: Please note for the Young Adult Option, the plan selection must be the same as the covered parent.

☐ **Network Core Plan** ☐ **Choice PPO Plan** ☐ **Consumer Core HDHP/HSA Plan**

HEALTH CARE COVERAGE INFORMATION
You must provide full name, gender, Social Security Number and date of birth for each person you enroll.

Dependents Coverage:

	Last Name	First Name	M.I.	Sex	Social Security	Date of Birth month	day	year	Add/Delete
Child				☐ F ☐ M					
Child				☐ F ☐ M					
Child				☐ F ☐ M					

Are you or any of your enrolled dependents covered by any other health insurance? ☐ Yes ☐ No

Name of insured _____ Carrier Name _____ Group Name _____ Group # _____

I have received, read, and understand the information explaining the Medical Plan Options. I authorize Pace University to bill me the appropriate premiums for the coverage that I have elected, if applicable. I understand that I am making a binding election concerning my medical plan benefits for the next plan year. I also understand that I will not be able to change my election prior to the next open enrollment period unless I have a qualified change in family status event. I understand my duty to notify the University within 31 days of any changes that affect the eligibility of any of my covered dependents; for example, marriage, divorce, or change in student status. I understand that the health plan is not liable to provide coverage to ineligible dependents. I understand that the Plan may use my personal health information for the purposes of treatment, payment, and health care operations and other uses in consistency with federal HIPAA regulations. The information supplied is true and complete.

Signature _____ Date_____

Employer Only:

Group Name: PACE UNIVERSITY Group #: SUBGROUP #_____

Employer Signature: _____ Date: _____

Qualifying Event Reason:_____ Qualifying Event Date:_____

Effective Date of Coverage_____ Termination Date: _____