



3505 Cadillac Ave, Suite O-201, Costa Mesa, CA 92626
 Phone: (844) 322-6632 Fax: (714) 241-9279

MEC/MVP EMPLOYEE ENROLLMENT FORM

EMPLOYER INFORMATION						
Employer Name:	Canvas InfoTech #A1411			DIVISION:		
Date of Hire:		Occupation:		Effective Date:		
EMPLOYEE INFORMATION						
First Name:			Last Name:			
Date of Birth:		Sex:	<input type="checkbox"/> M <input type="checkbox"/> F	Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced	
Social Security#		Telephone:		Email Address:		
Address:				Apartment #:		
City:		State:		Zip Code:		
Plan Selection: (Check One Box)	<input type="checkbox"/> MEC <input type="checkbox"/> MVP <input type="checkbox"/> <b style="background-color: yellow;">DECLINE			Additional Benefit	N/A	
DEPENDENT INFORMATION						
First Name	Last Name	Date of Birth	Sex	Social Security	Relationship	Plan Election
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> ENROLL <input type="checkbox"/> DECLINE
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Child	<input type="checkbox"/> ENROLL <input type="checkbox"/> DECLINE
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Child	<input type="checkbox"/> ENROLL <input type="checkbox"/> DECLINE
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Child	<input type="checkbox"/> ENROLL <input type="checkbox"/> DECLINE
LEGAL ACKNOWLEDGMENT						
1) I understand that if the above information is not complete or correct this coverage could be retroactively terminated.					Initial:	
2) I understand that if I decline coverage now and later want to enroll myself or my dependents, I may only be able to add coverage for myself or my dependents if I enroll for coverage within 30 days of a HIPAA Special Enrollment Event or at the next Open Enrollment Period.					Initial:	
3) I understand that enrollment in either the Minimum Essential Coverage (MEC) or MVP is required in order to avoid the Individual Mandate Penalty of the Affordable Care Act. By declining this coverage I may be responsible for a penalty of 2.5% of my income or \$695 per person in my family in 2017.					Initial:	
4) I understand that I may decline this plan and still purchase a plan in the State Healthcare Exchange, however, I may not be eligible to receive a subsidy. I may also be eligible for MediCal/MedicAid.					Initial:	
5) I understand that the MEC Choice and Limited Medical plan may exclude some coverage normally associated with health insurance plans. The MEC plan only covers preventative services.					Initial:	
6) I authorize my employer to deduct my portion of the premiums if any from my pay check. Signature confirms receipt of credible and affordable health benefit offering for 2017.					Initial:	
SIGNATURE:				DATE:		

IF YOU ARE ENROLLING IN THE MVP PLAN YOU MUST SIGN BELOW

SIGNATURE REQUIRED / AUTHORIZATION TO RELEASE MEDICAL INFORMATION FOR ENROLLMENT

I hereby authorize those physicians, medical practitioners, hospital, clinics, veteran's administration facilities, medical information services, urgent care facilities, pharmacy, pharmacy benefit manager, health plan, and other medical or medically related entities, insurance or reinsurance companies, and consumer reporting agencies that have information available as to the present or former physical health condition, including drug or alcohol or domestic abuse, and/or treatment of me or my dependents to release any and all such information, including, but not limited to, medical records, health care provider notes, laboratory tests and results, diagnoses, treatment, and prognoses. I understand the information obtained by use of this authorization may be used to determine eligibility for issuance of health coverage and eligibility for benefits under existing health coverage for me and my dependents. This authorization is not applicable to psychotherapy notes. I agree that a photographic copy of this authorization shall be as valid as the original and that this authorization shall be valid for 2 1/2 years from the date shown below. I further understand the information I authorize a person or entity to obtain and use may be re-disclosed and no longer protected by federal privacy regulations. I understand that I may request a copy of this authorization. I understand that I may revoke this authorization at any time in writing unless action has been taken in reliance on my authorization. Because this authorization is given as a condition of obtaining coverage, my revocation will not prevent the Insurer and/or Plan Sponsor from the right to contest a claim if another law so allows. Should I refuse to sign this authorization, I understand it may affect my enrollment in the benefit plan. All pages must be attached and complete, including this authorization for the application to be considered complete. Incomplete applications may be rejected.

Enrollee Signature **X** _____ Date (required) _____

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

IF YOU ARE DECLINING THE PLAN YOU MUST SIGN BELOW

SIGNATURE REQUIRED

The Patient Protection Affordable Care Act (PPACA) requires certain employers to offer an employer-sponsored medical plan with a certain level of benefits, and at a certain cost. This plan must be available to employees regularly working full-time hours as defined by PPACA. By completing this form, you are electing to decline my Employer's MVP Bronze Plan.

I hereby acknowledge that I was offered coverage under my Employer's MVP Bronze Plan, which offers minimum value, meets the PPACA definition of affordable, and also includes minimum essential coverage. I hereby acknowledge that through this offering, I am not eligible to receive a subsidy for a plan in the State Healthcare Exchange. I hereby release and hold harmless my Employer, its officers, agents and employees from any liability arising from the fact that I declined enrollment under my Employer's Bronze MVP plan and I hereby waive any rights to be afforded such coverage.

Declination Form

Full Name (Print): _____

****ONLY COMPLETE AND SIGN BELOW IF DECLINING COVERAGE****

Check reason:

I am covered under another group health plan

I am covered under an individual plan

Other: _____

Enrollee Signature **X** _____ Date (required) _____

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