VISTA Healthplans™

Vista Healthplan, Inc.
Employee Enrollment Application

PLEASE PRINT USING INK. INITIAL ALL CORRECTIONS.
ALL QUESTIONS MUST BE ANSWERED.

Indicate Reason for Application:
☐ Initial Enrollment ☐ Late Enrollment
☐ Add Dependent (*Provide supporting documentation*)
Date of Marriage / Date of Birth / Date of Adoption _____
☐ COBRA Date of Termination:_____
☐ Waiving coverage *(If so, complete name, address, social security number, sign, date and indicate reason for waiving)* _____

Last Name	First Name	M.I.

Social Security Number	E-Mail Address	Language Preference ☐ English ☐ Spanish ☐ Other_____

Address	Apt.	City	State	ZIP Code

Telephone Number **Home: ( )**
Work: ( )

Were you ever a member of VISTA or any of its affiliates or former affiliates? ☐Yes ☐No If yes, indicate member number.

Marital Status ☐ Single ☐ Married

Date of Hire Mo. Day Yr.

Product ☐ HMO ☐ Point of Service (POS) ☐ _____

Employment Status ☐ Active ☐ Retired ☐ COBRA *Termination Date:* _____

Will you be covered by any other health insurance or Medicare while covered by VISTA? ☐YES ☐NO If yes, indicate:
Insurance Co. Name: _____
Telephone Number: _____
Policy Number: _____
Effective Date: _____

Will your spouse or dependents applying for coverage be covered by any other health insurance or Medicare? ☐ YES ☐ NO If yes, indicate:
Insurance Co. Name: _____
Name of Policy Holder: _____
Telephone Number: _____
Policy Number:_____Effective Date: _____
Employer Name: _____

Have you been covered by any other health insurance within the last 12 months (or 18 months for late enrollees), as applicable? ☐ Yes ☐ No If yes, how long? _____

Name of Insurance Co.: _____ Identification #:_____Insurance Co. Phone #: _____ **Attach all applicable Certificates of Creditable.**

If you are applying for dependent coverage, please list each dependent below. Please indicate additional dependents on a separate sheet. EXCEPT FOR STUDENT DEPENDENTS OVER AGE 19, DEPENDENTS MUST MAINTAIN AT ALL TIMES THEIR PRIMARY RESIDENCE IN VISTA'S SERVICE AREA, OR DEPENDENT IS NOT ELIGIBLE FOR HMO COVERAGE.

Last Name (if different) / First Name	Soc. Sec. No.	Sex	Relationship	Birth Date Mo. Day Yr.	Weight	Height	PCP Name (HMO/POS Only)	Provider ID Number
A. ***SELF***	***LISTED ABOVE***		***SELF***					
Dependents* B.				Mo. Day Yr.				
C.				Mo. Day Yr.				
D.				Mo. Day Yr.				
E.				Mo. Day Yr.				

* If a dependent who is eligible for coverage has a different last name than that of the employee, you must attach copies of supporting documents showing evidence of his/her dependent status (birth certificate, court order for guardianship, marriage certificate, domestic partner registration, etc.). If dependent is unmarried and age 19 or older, please attach proof of (a) dependent status by providing a copy of your last IRS 1040 form, and (b) if student: a letter from registrar's office certifying current hours enrolled; or (c) if not a student but living in household: proof of legal residence (driver's license, etc.); or (d) if disabled: a physician's certification stating date and degree of disability.

ELECTION OF COVERAGE AND AUTHORIZATION

I understand that for HMO/POS members, all referrals for specialty care and services must be coordinated by my primary care physician unless otherwise required by State or Federal law or in accordance with the applicable Certificate of Coverage. All HMO/POS members must obtain a written referral form, which shall be provided by their primary care physician or by Vista Healthplan™, Inc. (VISTA™) prior to seeing any specialist, unless this requirement is waived by VISTA, State or Federal Law.

I authorize any licensed physician, hospital, health care provider, insurer or any other medical or insuring entity in possession of my and my dependents' medical records and information, including any and all mental health records and information, to release my medical records and information and those of my dependents to the primary care physician and VISTA. This information may be requested after we are accepted by VISTA to identify possible pre-existing conditions. I hereby provide VISTA with consent to use identifiable information for general treatment, payment or health care operations, including but not limited to, coordination of care, quality assessment, utilization review, fraud detection or accreditation purposes. If member identifiable information is to be used for any other purpose, VISTA will obtain specific authorization from me and my dependents as required.

I understand that newborns and adopted children, if adopted before the age of eighteen, are not subject to a pre-existing condition waiting period, if covered within 30 days but not later than 63 days after birth, adoption or placement. I agree that coverage for pre-existing conditions will not be provided until the specified waiting period indicated in VISTA's Certificate of Coverage or Group Master Contract is concluded. I understand that my dependents (if any) and I may be subject to a pre-existing condition exclusion until the required Certificate(s) of Creditable Coverage are received by VISTA.

I certify that all information and statements furnished by me are true and complete to the best of my knowledge. If I was asked to supply medical or other information, I understand, that any misrepresentation or omission of any information concerning any pre-existing conditions, impairments, or other requirements may result in the termination of my or my dependent's coverage. I understand my financial obligation for any charges incurred after the effective date of termination of coverage. I hereby acknowledge VISTA's right to require proof of any dependent's or spouse's or child's dependent status.

I understand that VISTA does not directly employ any participating providers or facilities. All health care providers and facilities are independent contractors and are not the agents or employees of VISTA.

I agree that if my dependents or I have not been continuously covered by creditable health insurance coverage within the last 12 months (18 months for late enrollees), as applicable, my dependents and I, as applicable, may be subject to a pre-existing condition exclusion.

If applying for HMO coverage, I certify that I maintain my primary residence in VISTA's Service Area or am regularly employed in the VISTA Service Area. I also certify that, except for student dependents over age 19, all dependents to be covered maintain their primary residence in the VISTA Service Area and dependent children are dependent on me for support and maintenance.

The Certificate of Coverage (or "Contract") can be obtained through (i) the VISTA website at www.vistahealthplan.com, (ii) by contacting your Group Benefit Administrator, or (iii) by calling the VISTA Customer Service Department at 1-866-VISTA-FL (1-866-847-8235) and requesting a hard copy of the Contract be mailed via U.S. regular mail. Your signature on this application represents acceptance of these delivery options.

I understand that 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 may be guilty of a felony of the third degree. VISTA may terminate coverage of any member who knowingly defrauds VISTA.

Employee Applicant Sign Here: X_____ **Date:** _____

TO BE COMPLETED BY EMPLOYER GROUP
(Representative/Employer Signature Required)

Employer Name	Group Number/Parent Code	Requested Effective Date	BP Code:	For VISTA Use Only

Date Submitted to VISTA	Employer Signature X	Processed by	Date