sidecar health

Sidecar Health Insurance Company
Group Major Medical Insurance

Step 1: Choose your plan and reason for enrollment.

Please list the Employer/Group Name: Siffrin, Inc.

Please indicate the reason for enrollment:

- ◯ Open Enrollment
- ◯ Special Enrollment (select for enrollment outside of Open Enrollment)

Date Special Enrollment event ocurred: _____

Select Special Enrollment reason below:

- ◯ New Hire
- ◯ New Dependent: marriage, domestic partnership, birth of a child, adoption of child
- ◯ Court Order to provide dependent coverage
- ◯ Loss of other health insurance coverage
- ◯ Other: _____(please explain)

Please indicate if this is new coverage, a change in coverage, or adding a dependent to existing coverage:

- ◯ New coverage
- ◯ Change in coverage
- ◯ Adding dependent to existing coveage

If changing coverage or adding a dependent to existing coverage, list your Member ID no. _____

Please check the plan option you wish to to enroll in:

☐ $5,000 deductible ☐ $2,000 deductible ☐ Waive Coverage

Step 2: Tell us about yourself.

First name	**Middle Initial**	**Last name**	**Suffix**

Home address		**Home address 2**	
City	**State**	**Zip code**	**County**
Mailing address (if different from home address)		**Mailing address 2**	
City	**State**	**Zip code**	**County**
Phone Number (including Area Code)			

Email address: _____

On behalf of myself and any covered dependents, I'm providing my email address because I want to receive information about my benefits by email or electronically. This may include my policy, certificate or Evidence of Coverage, billing, explanation of benefits, required notices and helpful or personalized information to get the most out of my benefits. I will make sure Sidecar Health has my most up to date email. These electronic communications may include specific details about me and my plan. I also understand that by providing my email address, information about my dependents may be sent by email or electronically. I know I (or my covered dependents) can change my mind at any time and request a free copy of specific materials by mail. To do either, I (or my covered dependents) will update communication preferences by going to sidecarhealth.com or calling Member Care.

Primary Language (other than English)	
Social Security Number (SSN)	
Sex ○ Female ○ Male	**Date of birth (mm/dd/yyyy)**

Step 3: Tell us about anyone who needs health coverage.

(If you have more people to include, make a copy of this page and attach to your enrollment form. Children must be under age 26.)

Person 2

First name	**Middle Initial**	**Last name**	**Suffix**
Relationship to You ○ **Spouse** ○ **Domestic Partner** ○ **Child**		**Social Security Number (SSN)**	
Address (if different than You)		**Address 2**	
City	**State**	**Zip code**	**County**
Sex ○ Female ○ Male		**Date of birth (mm/dd/yyyy)**	

Person 3

First name	**Middle Initial**	**Last name**	**Suffix**
Relationship to You ○ **Spouse** ○ **Domestic Partner** ○ **Child**		**Social Security Number (SSN)**	
Address (if different than You)		**Address 2**	
City	**State**	**Zip code**	**County**
Sex ○ Female ○ Male		**Date of birth (mm/dd/yyyy)**	

Person 4

First name	**Middle Initial**	**Last name**	**Suffix**
Relationship to You ○ **Spouse** ○ **Domestic Partner** ○ **Child**		**Social Security Number (SSN)**	
Address (if different than You)		**Address 2**	
City	**State**	**Zip code**	**County**

Sex ○ Female ○ Male	**Date of birth (mm/dd/yyyy)**

Person 5

First name	**Middle Initial**	**Last name**	**Suffix**
Relationship to You ○ **Spouse** ○ **Domestic Partner** ○ **Child**		**Social Security Number (SSN)**	
Address (if different than You)		**Address 2**	
City	**State**	**Zip code**	**County**
Sex ○ Female ○ Male		**Date of birth (mm/dd/yyyy)**	

Person 6

First name	**Middle initial**	**Last name**	**Suffix**
Relationship to You ○ **Spouse** ○ **Domestic Partner** ○ **Child**		**Social Security Number (SSN)**	
Address (if different than You)		**Address 2**	
City	**State**	**Zip code**	**County**
Sex ○ Female ○ Male		**Date of birth (mm/dd/yyyy)**	

Step 4: Your agreement and signature.

I, the undersigned, understand that:

- I'm responsible to let Sidecar Health and my employer know, in a timely manner, of any change that would make me or any dependent ineligible for coverage.
- I certify that each Social Security Number listed on this form is correct.
- I represent that I have read this section, and I agree to the coverage conditions.
- I represent the answers given to all questions on this enrollment form are true and accurate to the best of my knowledge and belief, and I understand they are being relied on by Sidecar Health for providing coverage to myself and my dependents. I also understand that any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an enrollment form or files a claim containing a false or deceptive statement is guilty of insurance fraud and, any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact found in this form may result in denial of benefits, rescission or cancellation of my coverage(s).

I sign this enrollment form for and on behalf of any eligible dependents and myself if covered by Sidecar Health. I am acting as their agent and representative.

This enrollment form cannot be altered by the undersigned after submission to Sidecar Health absent the acknowledgement and consent of Sidecar Health.

Please sign below

_____ _____

Primary Enrollee (or legal representative) Date