healthfirst
Health Insurance for New Yorkers

PLAN CHANGE / EMPLOYEE CLASS DEFINITION CHANGE REQUEST

This form may be used for plan changes and to update the employee class definition.
NOTE: These types of changes are allowed only during your initial open enrollment period or upon renewal. To enroll employees to the selected plans, they must live or work in one of the five NYC boroughs, or in Nassau or Suffolk counties.

Please choose one of these three ways to return this form:

- **Mail** it to Healthfirst Insurance Company, Inc. | P.O. Box 1566 | New York, NY 10008-1566
- **Contact Employer Services** at **1-855-949-3668** or **employerandbrokerservice@healthfirst.org**
- **Upload** it onto the Healthfirst portal upon renewal

Group Name _____ **Group Number** _____

☐ **Plan Change or** ☐ **Additional Plan Selection**

NOTE: If selecting both Pro **and** Pro Plus plans, the metal level cannot be the same.

Platinum	Gold	Silver	Bronze
☐ Healthfirst Platinum Pro EPO ☐ Healthfirst Platinum Pro Plus EPO (includes Adult Vision and Dental)	☐ Healthfirst Gold Pro EPO ☐ Healthfirst Gold 25/50/0 Pro EPO ☐ Healthfirst Gold Pro Plus EPO (includes Adult Vision and Dental) ☐ Healthfirst Gold 25/50/0 Pro Plus EPO (includes Adult Vision and Dental)	☐ Healthfirst Silver Pro EPO ☐ Healthfirst Silver 40/75/4700 Pro EPO ☐ Healthfirst Silver Pro Plus EPO (includes Adult Vision and Dental) ☐ Healthfirst Silver 40/75/4700 Pro Plus EPO (includes Adult Vision and Dental)	☐ Healthfirst Bronze Pro EPO ☐ Healthfirst Bronze 6650 Pro EPO ☐ Healthfirst Bronze 8150 Pro EPO ☐ Healthfirst Bronze Pro Plus EPO (includes Adult Vision and Dental) ☐ Healthfirst Bronze 6650 Pro Plus EPO (includes Adult Vision and Dental)
☐ Age 29 Rider (extends dependent coverage through age 29)	☐ Age 29 Rider (extends dependent coverage through age 29)	☐ Age 29 Rider (extends dependent coverage through age 29)	☐ Age 29 Rider (extends dependent coverage through age 29)

Rates for the selected plan(s) by tier:

Single: _____ Couple: _____

Parent/Child(ren): _____ Family: _____

Valid Employer Class(es): An employer may elect to offer coverage to a class of employees based on conditions pertaining to employment: geographic situs of employment, earnings, method of compensation, hours, and occupational duties. Coverage may be limited to specific class(es) of employees if they are the only employees offered coverage. Employees who work fewer than 20 hours per week are not eligible employees and may not enroll in any Healthfirst plans.

To be **completed only** if the initial selection needs to be updated. Otherwise, proceed to signature section.

New Employee Eligibility/CLASS I	New Employee Eligibility/CLASS II
Definition of Class I: _____	**Definition of Class II:** _____
Option 1) Employees are eligible for coverage as of the date on which the employee completes:	**Option 1)** Employees are eligible for coverage as of the date on which the employee completes:
☐0 days ☐ 30 days ☐ 60 days ☐ 90 days of continuous service.	☐0 days ☐ 30 days ☐ 60 days ☐ 90 days of continuous service.
Note: Period must not exceed 90 days. Employees will have 30 days to enroll once eligible for coverage. Coverage will be effective as of the date that the employee became eligible. **Termination will be the date of termination of employment.** **OR**	**Note:** Period must not exceed 90 days. Employees will have 30 days to enroll once eligible for coverage. Coverage will be effective as of the date that the employee became eligible. **Termination will be the date of termination of employment.** **OR**
Option 2) Employees are eligible for coverage as of the first day of the calendar month coinciding with or next following the date on which the employee completes:	**Option 2)** Employees are eligible for coverage as of the first day of the calendar month coinciding with or next following the date on which the employee completes:
☐ 0 days ☐ 30 days ☐ 60 days	☐ 0 days ☐ 30 days ☐ 60 days
Note: Period must not exceed 90 days. Employees will have 30 days to enroll once eligible for coverage. Coverage will be effective as of the date that the employee became eligible. **Termination will be the last day of the calendar month.**	**Note:** Period must not exceed 90 days. Employees will have 30 days to enroll once eligible for coverage. Coverage will be effective as of the date that the employee became eligible. **Termination will be the last day of the calendar month.**
Waiting Period for Rehires:	**Waiting Period for Rehires:**
Waiting period waived for rehires? ☐Yes ☐No	Waiting period waived for rehires? ☐Yes ☐No
If yes, waived if rehired within ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days	**If yes**, waived if rehired within ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days

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The details below are required:

I, _____ **(Print Name and Title)**, hereby certify that I am electing to renew my group's Healthfirst policy with the information contained herein. I understand that this policy will be available to me for the duration of twelve (12) months and is subject to the review and approval of the Healthfirst enrollment department.

_____

Signature Date