Prime Healthcare

Medical Expense Reimbursement Program (MERP) Enrollment Form

Fields indicated with (*) are required.

EMPLOYEE INFORMATION

*First Name	Middle Name	*Last Name	Suffix (i.e., Jr, Sr,)

*Email	*Mobile Number	*Employee SSN/ID

*Birth Date (mm/dd/yyyy)	*Hire Date (mm/dd/yyyy)	*Date eligible for MERP (mm/dd/yyyy)	Gender ☐Male ☐Female

*Facility	*Department

*Mailing Address

*City	*State	*Postal Code

Home Address *(if different than mailing address above)*

City	State	Postal Code

DEPENDENT INFORMATION (IF APPLICABLE)

Select One	First Name	Middle Name	Last Name	Suffix (i.e., Jr, Sr,)
☐Spouse ☐Child Dependent	Birth Date (mm/dd/yyyy)	SSN/ID	Gender ☐Male ☐Female	Employer
Select One ☐Child Dependent 1	First Name	Middle Name	Last Name	Suffix (i.e., Jr, Sr,)
	Birth Date (mm/dd/yyyy)	SSN/ID	Gender ☐Male ☐Female	Employer
Select One ☐Child Dependent 2	First Name	Middle Name	Last Name	Suffix (i.e., Jr, Sr,)
	Birth Date (mm/dd/yyyy)	SSN/ID	Gender ☐Male ☐Female	Employer
Select One ☐Child Dependent 3	First Name	Middle Name	Last Name	Suffix (i.e., Jr, Sr,)
	Birth Date (mm/dd/yyyy)	SSN/ID	Gender ☐Male ☐Female	Employer
Select One ☐Child Dependent 4	First Name	Middle Name	Last Name	Suffix (i.e., Jr, Sr,)
	Birth Date (mm/dd/yyyy)	SSN/ID	Gender ☐Male ☐Female	Employer

Total Number of Dependents Enrolling:

COVERAGE SELECTION

*Please select one of the following enrollment tiers.

☐EE only ☐EE & Spouse ☐EE & child(ren) ☐Family ☐Child(ren) only ☐Spouse only ☐Spouse + child(ren)

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TO SUBMIT:
Please return to your local HR or for COBRA return to HR Simplified

PINNACLE™ CLAIMS MANAGEMENT, INC.

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SIGN AND ACKNOWLEDGE

Health Savings Account (HSA) Acknowledgment

☐ *I understand that making contributions to a Health Savings Account (HSA) will render me ineligible to participate in MERP.

Terms and Conditions

☐ *I agree to comply with the Terms and Conditions of the MERP and understand that any fraudulent claims will result in the immediate termination of my participation in the program.

Fraud Warning

☐ *I understand that submitting fraudulent claims or providing false information may result in legal action of any benefits obtained improperly.

Attestation

This attestation applies to individuals who have elected the MERP and who waive coverage in the Prime Healthcare group medical plan.
By completing this enrollment session and electing to participate in the MERP plan, I certify that:

☐ *Prime Healthcare has offered me, and my eligible dependents a group medical plan that does not consist solely of "excepted benefits" under the Affordable Care Act of 2010 ("ACA").

☐ *I, and/or my spouse and/or my dependents are enrolled in a group health plan of another employer (such as my spouse's employer) (my Alternate Group Health Plan) that does not consist solely of "excepted benefits" under ACA (such as limited-scope dental or vision coverage), nor does it consist solely of a "health reimbursement arrangement" (reimbursement of health care expenses up to a dollar limit).

☐ *I further certify that my alternate coverage is not a:

- High Deductible Health Plan (HDHP) with active contributions to a health savings account (HSA); however, as long as your spouse is not enrolled in the MERP, your spouse may contribute to an HSA and use the HSA funds. The HSA funds CANNOT be used for medical expenses for members enrolled in the MERP. All members may use the HSA funds for dental and/or vision as long as those expenses are not covered by the MERP.
- Medicaid, Medicare, or Tricare
- Healthcare Exchange Policy made available thru the Affordable Care Act
- Individual policy or Limited Benefit Health Plan

*Employee's Signature	Spouse or Dependent 18+ Signature (If enrolling)	*Date (mm/dd/yyyy)

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