Harrowing Heights

Send completed form, requird documentation, and premium payment to: Harrwoing Heights Inc., 301 Daniel Hall, Clemson, SC 29631

Enrollment by Qualifying Event

This plan must accompany the BlueCross Blue Shield Enrollment Form

Employee Name	First Middle Initial Last	Social Security Number	– –
Division		Employee ID	

LIST OF DEPENDENTS TO BE INSURED

Dependent	First Name	MI	Last Name	DOB (MM/DD/YY)	Gender	SS Number
Spouse						
Child 1						
Child 2						
Child 3						

Identify the qualifying event which caused the loss of other medical coverage for you and your eligible dependents. You must submit the appropriate required documentation, proof of prior coverage, and this completed form. Application for enrollment must be submitted within 31 days in which the qualifying event occurred. Improper documentation will result in a return of premium and a delay of coverage.

Qualifying Event Date: ____ / _____ / _____

	QUALIFYING EVENT	DOCUMENTATION REQUIRED
	Please check the box below that is applicable to your situation. A box MUST be checked and the appropriate required documentation MUST accompany this form.	Letter of Ineligibility (lost coverage) is required for any reason listed.
☐	Loss of eligibility (does not include loss due to failure to pay premiums or termination of coverage for cause) Cause of Loss:_____ _____ _____	Written documentation from insurance company, providing the names of the covered participants, date coverage ends and the reason for loss of eligibility.
☐	Acquired a new dependent – spouse (and adding other previously eligible dependents)	Copy of marriage certificate
☐	Acquired a new dependent – newborn, adopted child, child arriving from another country (and adding other previously eligible dependents)	Copy of birth certificate/birth record for newborn; or proper vis documentation for child(ren) arriving from another country

STUDENT SIGNATURE:_____ DATE: _____

Harrowing Heights Inc.
Qualifying Event Enrollment Form

(PLEASE PRINT CLEARLY OR TYPE)

EMPLOYEE INFORMATION							
Employee Name	First		MI		Last		
Local & ID Mailing Address	Street			City/State		Zip	
Permanent Address	Street			Citty/State		Zip	
Email	(a confirmation email will be sent upon enrollment)			Phone/Cell Number			
Male		Female		DOB	(MM/DD/YYYY)	SSN	

LIST DEPENDENTS TO BE INSURED BELOW. Dependent coverage is available only if the student is also insured. Dependent coverage must be the exact same coverage period of the Insured; and therefore, will expire concurrently with that of the student.

DEPENDENT INFORMATION						
Dependent	First Name	MI	Last Name	DOB (MM/DD/YYYY)	Gender (M/F)	SSN
Spouse						
Child 1						
Child 2						
Child 3						

NOTICE TO EMPLOYEE. Coverage will be effective the date of the Qualifying Event if required documentation and form are received within 31 days in which the Qualifying Event occurred, unless otherwise stated in the Master Policy By signing below, the student acknowledges the following: 1) Rates are not pro-rated other than as listed on this enrollment form; 2) Student meets the eligibility requirements for this coverage as described in the brochure; 3) If it is later determined that the student is not eligible, coverage will be deemed to have not been in force and the premium will be returned; and 4) Other than eligibility or entry into the Armed Forces, the premium is not refundable. It is the student's responsibility to make a timely renewal payment. This plan is underwritten by Blue Cross and Blue Shield of South Carolina.

I understand my information is protected by privacy laws and will be released only in accordance with these laws

My signature below represents that I have read and understand the Student Health Insurance Plan brochure and agree to accept it as applicable to me regarding the terms and conditions stated therein.

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

SIGNATURE:_____ DATE:_____

Please note this enrollment form cannot be processed unless you make all your coverage selections on the next page. CONTINUE ON NEXT PAGE

Harrowing Heights Inc.
Qualifying Event Enrollment Form

Employee Name:_____ Employe ID:_____

(PLEASE CHECK ALL THE APPROPRIATE BOXES)

The monthly rate is to be used in the calculation of your total premium due only if the Covered Person has a qualifying event, such as marriage, birth, loss of coverage due to age limitation, etc. The monthly rate would be paid beginning in the month which the qualifying event occurred through the end of the current coverage period.

Note: If this enrollment is for a dependent only, the dependent is allowed to purchase only the number of months that will allow them to reach the termination date of the student's existing coverage.

Employee/Insured Classification:

- ☐ Full Time Employee
- ☐ Part Ime Employee
- ☐ Vendor/Contractor

PERIOD RATES AND COVERAGE DATES			
COVERAGE DATES	MONTHLY RATE		*CALCULATE TOTAL PREMIUM DUE
	Coverage	Monthly Rate	EXAMPLE: 81.41*12=976.92
Qualifying event Date ____/____/____ through termination (rolls over yearly)	Full Time	$ 81.41	$ 81.41 * ____ Months= $
	Part Time	$ 81.41	$ 81.41 * ____ Months= $
	Spouse	$ 81.41	$ 81.41 * ____ Months= $
	Each Child	$ 81.41	$ 81.41 * ____ Months= $
	Three or more Children		$ 244.23 * ____ Months= $
	TOTAL		$
NO CHARGE FOR 1ST MONTH OF NEW-BORNS	*TOTAL PREMIUM PAID MONTHLY		

The billed amount includes administrative fees, non-insured services, and certain federal, health care fees/assessments. Please use the chart above to calculate total amount due.

Payment is automatically deducted from weekly pay checks, if enrollee wishes to pay by card or check every month please contatact your division head or the HR manager.

☐ By signing this form, I hereby understand and give my consent to Harrowing Heights Inc. and Blue Cross Blue Sheild to withdraw insurance payments from my weekly pay checks. I have read and understand this insurance enrollment form.

Employee Signature:_____Date:_____