Plan Name: **Five Points Health Benefits, LLC**

Group No:_______ Effective Date: ---/---/2025

Broker: ____________________

☐ Open Enrollment ☐ New Enrollment

Individual & Family RBP Plan

Individual name: ____________________

Plan Type: Reference Based Pricing - (RBP)

Enrollment Application

Coverage under FIVE POINTS BENEFIT PLANS is designed to assist participants in satisfying the Individual & Family mandate portion of the Affordable Care Act to receive the tax credit or subsidy before the next exchange open enrollment unless you have a qualifying life event.

THIS INFORMATION MUST BE COMPLETED – PLEASE PRINT in INK

Please Note: You ACCEPT HEALTH COVERAGE through Five Points Benefit Plans, LLC by completing and signing this form. Incomplete information will delay delivery of ID cards and processing of claims.

Social Security Number:_______/_____/_______ Gender: ☐ Male ☐ Female Date of Birth: _____/__/_____

Your Name: ____________________

Last Name First Name Middle Initial Suffix (Ex: Jr, Sr.)

Address:____________________ Apt #:__________

City:____________ State:______ Zip Code:________ Occupation:__________

Home Phone: (_____)______-________ Cell Phone: (______)_______-________

Email Address: ____________________

________: MEM Only | MEM + Spouse | MEM + Child | MEM + Family

Are YOU Selecting Benefit Plan Coverage offered by Five Points Health Benefit Plans for **your spouse and/or dependent child(ren)?**

O **Yes (List Dependents below)** O **No (Skip to next page to ACCEPT for Yourself)**

ONLY LIST YOUR FAMILY MEMBERS TO BE COVERED* (Use separate sheet for additional child(ren). Below please list the Name, SS# and Relationship to Member of any dependent(s).	**Social Security Number xxx-xx-xxxx**	**√ SELECT COVERAGE**	**Relationship to Member**	**Gender**	**Date of Birth xx/xx/xxxx**
Spouse *Last Name First Name Middle Initial*		☐ Yes ☐ No	Spouse	☐ Male ☐ Female	
Dependent: *Last Name First Name Middle Initial*		☐ Yes ☐ No		☐ Male ☐ Female	
Dependent: *Last Name First Name Middle Initial*		☐ Yes ☐ No		☐ Male ☐ Female	
Dependent: *Last Name First Name Middle Initial*		☐ Yes ☐ No		☐ Male ☐ Female	

You MUST Accept coverage by signing

Statement of Application and Enrollment for RBP Individual & Family

By my authorized signature below, I elect TO ENROLL in my Health Benefit Plan offered by Five Points Benefit Plans, LLC.

1) I authorize Five Points Benefit Plans, LLC to deduct from me a monthly payment for health coverage.
2) I acknowledge that if I/we are qualified to receive a tax credit on the Health Insurance Exchange and enroll in Five Points' Health Benefit Plan then I/we may be disqualified from receiving a Tax Credit or subsidy on the Health Insurance Exchange, prior to the next open enrollment period.
3) *I, on behalf of myself and my dependents (if any), understand that the following is acknowledged by my signature below that the plan benefits have been explained and I fully understand them.*
4) *I further affirm that I have read completely and understood the above, and if ANY of the above information changes, I will promptly notify Five Points Benefit Plans, LLC or Plan Administrator.*

The RBP plan members are responsible for finding providers that will accept the RBP payments. There is no network or established set of required providers. Members can go to any provider or facilities they choose. However, the plan can identify providers and facilities who commonly accept the plan's reimbursement rates as payment in full, without requiring a network contract or provider agreement.

RBP open network may result in balance billing. We would mitigate and advocate on your behalf and resolve your claim dispute through mediation if it does.

I consent that I have read and fully understand my Health Plan Coverage, Benefits and any limitations set forth in my plan policies and documents, including the Schedule of Benefits (SOB). Reference Base Pricing Limited Benefit Plan with Limitations and Deductibles.

Member Signature: X ______________________________ **Date:**_____/_____/_____

Printed Name: ______________________________ **Social Security #:**_____-_____-_____

NOTICE OF HIPAA PRIVACY RULE: *The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other individually identifiable health information (collectively defined as "protected health information") and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of protected health information and sets limits and conditions on the uses and disclosures that may be made of such information without an individual's authorization. The Rule also gives individuals rights over their protected health information, including rights to examine and obtain a copy of their health records, to direct a covered entity to transmit to a third party an electronic copy of their protected health information in an electronic health record, and to request corrections.*