

ENROLLMENT/CHANGE FORM

A EMPLOYEE INFORMATION (To Be Completed By Employee)

I SELECT THE FOLLOWING PLAN FOR MYSELF AND MY DEPENDENTS: PPO/Health Assurance Coordinated Care PPO/Health Assurance PPO Dental

LAST NAME	FIRST NAME	MI	M/F	BIRTH DATE	SOCIAL SECURITY NO.	COVERAGE TYPE <input type="checkbox"/> SINGLE <input type="checkbox"/> PARENT/CHILD <input type="checkbox"/> FAMILY <input type="checkbox"/> PARENT/CHILDREN <input type="checkbox"/> HUSBAND/WIFE	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED (date) _____ <input type="checkbox"/> DIVORCED (date) _____ <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED
ADDRESS		STATE		ZIP CODE	COUNTY	HOME PHONE ()	DATE OF HIRE _____ <input type="checkbox"/> ACTIVE <input type="checkbox"/> RETIRED
CITY		PRIMARY CARE PHYSICIAN # <i>If residing in Coordinated Care PPO</i>		BUSINESS PHONE ()		PRIMARY CARE PHYSICIAN	

B FAMILY MEMBERS TO BE COVERED OR DELETED

COVER OR DELETE	FULL NAME (LAST, FIRST, MI)	SEX	RELATIONSHIP	BIRTH DATE	STUDENT OR DISABLED	SOCIAL SECURITY NO.	PRIMARY CARE PHYSICIAN	SITE CODE/PCP ID
E	D 01	M/F	Spouse	/ /				
E	D 02	M/F		/ /	S/D			
E	D 03	M/F		/ /	S/D			
E	D 04	M/F		/ /	S/D			
E	D 05	M/F		/ /	S/D			
E	D 06	M/F		/ /	S/D			

C OTHER INSURANCE

Do you or your dependents have other coverage? No Yes If Yes, please complete the following:

POLICY HOLDER	BIRTH DATE	EMPLOYER	INSURANCE COMPANY
LIST DEPENDENTS COVERED	BIRTH DATE	EFF. DATE	CONTRACT NO./GROUP NO.

Do you or your dependents have Medicare Coverage? Yes No If Yes, please complete the following:

NAME	MEDICARE ID NO.	PART A EFF. DATE	PART B EFF. DATE
NAME	MEDICARE ID NO.	PART A EFF. DATE	PART B EFF. DATE

D CONDITIONS OF ENROLLMENT

I REPRESENT THAT ALL INFORMATION SUPPLIED ON THIS FORM IS TRUE AND COMPLETE. I HEREBY AGREE TO THE CONDITIONS OF ENROLLMENT ON THE REVERSE SIDE OF THIS APPLICATION.

Employee's Signature _____ Date _____ 20__

E EMPLOYER INFORMATION (To Be Completed By Employer)

GROUP NO.	GROUP NAME	EFFECTIVE DATE	EMPLOYER'S SIGNATURE	DATE
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ENROLL

<input type="checkbox"/> OPEN ENROLLMENT	<input type="checkbox"/> REINSTATE	<input type="checkbox"/> ADD DEPENDENT (reason for addition) _____	<input type="checkbox"/> CANCEL COVERAGE (reason) _____
<input type="checkbox"/> NEW HIRE	<input type="checkbox"/> COBRA	<input type="checkbox"/> DELETE DEPENDENT (reason for deletion) _____	<input type="checkbox"/> NAME CHANGE
<input type="checkbox"/> OTHER _____	<input type="checkbox"/> DIRECT PAY	<input type="checkbox"/> ADDRESS CHANGE	PREVIOUS NAME _____

IMPORTANT: ALL FIELDS ON THIS FORM MUST BE COMPLETED FOR TIMELY PROCESSING.

SEE REVERSE SIDE FOR CONDITIONS OF ENROLLMENT.

(TO BE COMPLETED BY HEALTH ASSURANCE)
DATE RECEIVED _____