

ENROLLMENT/CHANGE FORM

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

A EMPLOYEE INFORMATION (To Be Completed By Employee)

I ELECT THE FOLLOWING PLAN FOR MYSELF AND MY DEPENDENTS: PPO/HealthAssurance Coordinated Care PPO/HealthAssurance (POS) HealthAssurance Flex

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

B FAMILY MEMBERS TO BE COVERED OR DELETED

ENROLL 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		/ /				
E	D 03	M/F		/ /				
E	D 04	M/F		/ /				
E	D 05	M/F		/ /				
E	D 06	M/F		/ /				

C OTHER INSURANCE Do you or your dependents have other coverage? No If Yes complete the following:

List all family members with Medical Health Insurance in addition to HealthAssurance coverage.

POLICY HOLDER	BIRTH DATE	EMPLOYER	INSURANCE COMPANY
LIST DEPENDENT'S COVERED			

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 <td></td> <td></td> <td></td>			
NAME <td></td> <td></td> <td></td>			

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

OPEN ENROLLMENT REINSTATE ADD DEPENDENT (reason for addition) _____ CANCEL COVERAGE (reason) _____

NEW HIRE (date of hire: _____) (reason: _____) DELETE DEPENDENT (reason for deletion) _____ NAME CHANGE _____

OTHER _____ (date of hire: _____) COBRA (qualifying event: _____) ADDRESS CHANGE _____ WIDOWED SEPARATED

DIRECT PAY _____

(TO BE COMPLETED BY HEALTHASSURANCE)

DATE RECEIVED _____