

# Enrollment Application



## Participant Information

Last Name \_\_\_\_\_ First \_\_\_\_\_ Initial \_\_\_\_\_  
 Participant ID \_\_\_\_\_ Date of Hire/Rehire \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_

## Employment Information

Employer \_\_\_\_\_ Division/Location/Local \_\_\_\_\_  
 Occupation \_\_\_\_\_

## Insurance Information

Are you or any of your dependents covered by any other medical or dental coverage? Yes \_\_\_\_\_ No \_\_\_\_\_  
 If yes, please put a check next to those who have such coverage: Yourself \_\_\_\_ Your Spouse \_\_\_\_ Children \_\_\_\_  
 Name of Carrier \_\_\_\_\_  
 Policy # \_\_\_\_\_ Type of Coverage \_\_\_\_\_  
 Is member or dependent Medicare eligible? If yes, effective dates: Part A \_\_\_\_\_ Part B \_\_\_\_\_  
 Medicare Eligible Last Name \_\_\_\_\_ First \_\_\_\_\_ Initial \_\_\_\_\_

## Insurance Beneficiary

Name \_\_\_\_\_ Relationship to you \_\_\_\_\_

## Dependents

Are you under court order to provide health coverage? Yes \_\_\_\_\_ No \_\_\_\_\_  
 If you answered yes, please attach the Qualified Medical Child Support Order (QMCSO) to this form.  
 Below, please list all dependents to be covered:

	Last Name	First Name	Check One	Rel. to Employee	Date of Birth	Social Security Number
<b>Self</b>			Female _____ Male _____			
Spouse			Wife _____ Husband _____			
Child			Daughter _____ Son _____			
Child			Daughter _____ Son _____			
Child			Daughter _____ Son _____			
Child			Daughter _____ Son _____			

I have completed this application and believe it to be true and accurate to the best of my knowledge. I understand that the failure to disclose true and accurate information may result in the immediate termination of the benefits. I understand that the benefits will not be in effect until I have satisfied the eligibility requirements for coverage under the Plan. I hereby authorize any physician, medical practitioner, hospital, clinic, veterans administration facility, other medical related facility, insurance or reinsurance company or consumer reporting agency having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition, including drug or alcohol abuse, and/or treatment of me or my named dependents, to give to the Plan, its legal representative, management care firm, pre-certification or utilization review firm, any and all such information.

Signature \_\_\_\_\_ Date \_\_\_\_\_

----- For Plan Manager Use Only -----

Effective Date \_\_\_\_\_ Class \_\_\_\_\_ Division Code \_\_\_\_\_ Client Code \_\_\_\_\_