



Reason for Application

- New Hire
- Open Enrollment
- Add/Delete Dependents
- Loss of Prior Coverage

P.O. BOX 71490, Phoenix, AZ 85050
Phone: 1-888-419-6139 Fax: 623-889-7299

Instructions page 1: Complete the enrollment form in full in ink. Please print or type.

Section 1

Type of coverage:

EMPLOYEE ONLY

FULL FAMILY

Section 2

EMPLOYED BY: _____ DATE OF HIRE _____ TITLE _____

LAST NAME _____ FIRST _____ INITIAL _____ DATE OF BIRTH _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PHONE NUMBER _____ SOCIAL SECURITY NUMBER _____

Please check one: Native Non Native

SEX: Male Female

MARITAL STATUS: Single Married

Date of Marriage or Divorce _____ Number of dependent children **under** Age 19: _____ and if spouse is 65 or Older (yes) or (no)?

NAME OF DEPENDENT	RELATIONSHIP	Gender	DATE OF BIRTH	Social Security Number (Required by Medicare)
*	<u>*spouse</u>	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Section 3

Other Coverage Information

Do you and your family members have any additional group health coverage (including Medicare)? YES NO
If yes, please provide Carrier Name, Policy#, Effective date and who is covered under the Plan:

Section 4

To Refuse or Cancel Coverage

I do NOT wish to apply for, or wish to cancel Employee Family

Reason for refusing coverage: Other coverage Covered by Spouse Medicare/Medicaid

Other _____

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Instructions page 2 continued: Complete the form in full in ink. Please print/type (except for signature).

Section 5 Change of Coverage:

To Add Coverage to An Existing Plan: If change is due to marriage, or birth show date and reason
(Please attach copy of birth certificate, marriage certificate, full-time student status form)

I wish to add: Employee Dependent Spouse Full Family

I wish to delete: Employee Dependent Spouse Full Family

Reason for Change: _____

Date of Marriage: _____ Date of Divorce _____

Date of Birth: _____ Date "other" Coverage effective _____ Termed _____

Section 6

Beneficiary's Full Name (s) _____

Relationship _____

Section 7

I authorize payroll deductions for my share, if any, of the cost of the coverage(s) applied for.

I agree that:

(1) No coverage will be effective until the effective date assigned by the plan administrators following its approval of this application;

(2) No agent has authority to waive any requirement or a complete answer to any question;

(3) My employer shall represent me when receiving notices (including contribution and termination notices), when transmitting change requests and other information and when paying my contribution for this coverage.

I certify that all statements are complete and true to the best of my knowledge, that any contract which may be issued to me shall be binding only if each statement included in this application is complete and true.

In accordance with HIPAA regulations concerning Protected Health Information (PHI), I authorize any physician, medical facility, insurer, employer having information as to employment, medical coverage, or medical care, treatment or advice for any physical or mental condition of me, my spouse, or my children, or any other non-medical information, to release such information to it's administrators to determine eligibility for coverage.

I agree that the administrator may release such information to its representatives or reinsurers or as permitted by law.

I understand that any charge involved for the cost of these records will be my responsibility.

I represent that all statements and answers made in this application and on any attached papers are complete and true

A copy is valid as the original.

Signature _____ Date _____

Please supply Certificate of Creditable Coverage when applying.