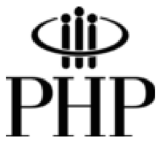

# MEDICAL ENROLLMENT FORM

**For PHP use Only**

**THIS SECTION TO BE COMPLETED BY EMPLOYER**

**Employer Name** ________________ **Benefit Plan #:** ________ **Employee Division** ________

Effective Date ________ Date of Employment ________ # of Hours Worked Weekly ______

Status: ☐ Full Time ☐ Part Time ☐ Retiree

☐ **COBRA ONLY:**
Last Day Worked ________
FMLA End Date ________

Date of Return from Layoff ________ Date of Part-Time to Full-Time ________

Date of Return from Leave of Absence ________ Date of Qualifying Event ________
(Please attach documentation such as court documents, Certificate of Creditable Coverage, etc.)

**THIS SECTION TO BE COMPLETED BY EMPLOYEE**

| SS # (Required) | Last Name | First Name | Middle Initial |
|---|---|---|---|
| Address | City | State | Zip |
| Home Phone | Work Phone | Email Address | Date of Birth |

| Medical ☐ Yes ☐ No | ☐ Male ☐ Female | Marital Status ☐ Single ☐ Married | Regular tobacco use within the past six months? (defined as four or more times per week on average, excluding religious or ceremonial use.) ☐ Yes ☐ No |
|---|---|---|---|

If yes to last question, when was the last time?________ Would you like the opportunity to participate in a Smoking Cessation Program? ☐ Yes ☐ No

**Application for HEALTH Coverage (check one):** ☐ **Employee only** ☐ **Employee & Spouse** ☐ **Employee & Children** ☐ **Family**

**EMPLOYEE/DEPENDENT DATA** List all Dependents eligible for Coverage. A Dependent is a person who is: 1) the Subscriber's legal spouse; 2) a child of the Subscriber who is a son, daughter or step-child or a child subject to legal guardianship regardless of support level; 3) a grandchild or other blood relative of the Subscriber who depends on the Subscriber for more than 50% of total support; 4) a child of the Subscriber who is recognized under a QMCSO as having a right to enroll under the Contract. List last name if different from employee.

| Relationship | Dependents Name (Last Name, First Name, M.I., and address if different) | Medical Coverage | Marital Status | Gender | Social Security # (required for Federal reporting) | Birth Date Mo./Day/Yr. |
|---|---|---|---|---|---|---|
| Spouse | | ☐ Yes ☐ No | | ☐ Male ☐ Female | | |
| | Regular tobacco use within the past six months? (defined as four or more times per week on average, excluding religious or ceremonial use) ☐ YES ☐ NO<br>If yes, when was the last time?________ Would you like the opportunity to participate in a Smoking Cessation Program? ☐ YES ☐ NO | | | | | |
| | | ☐ Yes ☐ No | ☐ S ☐ M | ☐ Male ☐ Female | | |
| | Regular tobacco use within the past six months? (defined as four or more times per week on average, excluding religious or ceremonial use) ☐ YES ☐ NO<br>If yes, when was the last time?________ Would you like the opportunity to participate in a Smoking Cessation Program? ☐ YES ☐ NO | | | | | |
| | | ☐ Yes ☐ No | ☐ S ☐ M | ☐ Male ☐ Female | | |
| | Regular tobacco use within the past six months? (defined as four or more times per week on average, excluding religious or ceremonial use) ☐ YES ☐ NO<br>If yes, when was the last time?________ Would you like the opportunity to participate in a Smoking Cessation Program? ☐ YES ☐ NO | | | | | |
| | | ☐ Yes ☐ No | ☐ S ☐ M | ☐ Male ☐ Female | | |
| | Regular tobacco use within the past six months? (defined as four or more times per week on average, excluding religious or ceremonial use) ☐ YES ☐ NO<br>If yes, when was the last time?________ Would you like the opportunity to participate in a Smoking Cessation Program? ☐ YES ☐ NO | | | | | |
| | | ☐ Yes ☐ No | ☐ S ☐ M | ☐ Male ☐ Female | | |
| | Regular tobacco use within the past six months? (defined as four or more times per week on average, excluding religious or ceremonial use) ☐ YES ☐ NO<br>If yes, when was the last time?________ Would you like the opportunity to participate in a Smoking Cessation Program? ☐ YES ☐ NO | | | | | |

**PLEASE COMPLETE REVERSE SIDE**

**COORDINATION OF BENEFITS INFORMATION:** HAVE YOU EVER BEEN A POLICYHOLDER OF PHP BEFORE? ☐ Y ☐ N

On the date that Coverage is to be effective, will you or your Dependent(s) have any other Coverage? ☐ Y ☐ N If yes, complete the following:

Health Plan Name________________ Policy/Group/ID Number________________

Claims Address/Phone Number________________ Effective Date________ Termination Date________

Policyholder's Name________________ Policyholder's Social Security Number________________

Covered Individuals________________ Policyholder's Birth Date________________

Company through which coverage is held________________ ☐ Medicare Plan A (Hospital only) ☐ A & B (Hospital & Medical)

**REFUSAL OF COVERAGE**

I have decided not to apply for Coverage for: **MEDICAL:** ☐ **Employee** ☐ **Children** ☐ **Spouse**

Reason:________________ Employee Signature: ________________ Date:________

**I (WE) HEREBY REPRESENT** that all statements and answers herein are full, complete and true. These statements and answers are to be considered as the basis for Coverage under the Plan. I understand that (1) this enrollment form constitutes a part of the Plan Contract and (2) no Coverage will be effective until the date specified by the Plan.

**I/WE REALIZE THAT KNOWINGLY FALSE INFORMATION OR INTENTIONAL OMISSIONS IN THIS FORM MAY RESULT IN CANCELLATION OF COVERAGE AND MAY BE GROUNDS FOR THE PLAN TO COLLECT DAMAGES OR ALTER ITS COVERAGE.**

**EMPLOYEE SIGNATURE:**________________ Date:________

(Signature is required even if refusing coverage)

**SPOUSE SIGNATURE:**________________ Date:________

(Signature is required even if refusing coverage)

**DEPENDENT SIGNATURE:**________________ Date:________

(Signature is required even if refusing coverage)

**DEPENDENT SIGNATURE:**________________ Date:________

(Signature is required even if refusing coverage)

**DEPENDENT SIGNATURE:**________________ Date:________

(Signature is required even if refusing coverage)

**PLAN ADMINISTRATOR SIGNATURE:**________________ Date:________

**IF YOU PREFER TO RETURN THIS FORM CONFIDENTIALLY, PLEASE PLACE IN A SEALED ENVELOPE.**

***Physicians Health Plan of Northern Indiana, Inc.***

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