MEDICAL & DENTAL ENROLLMENT FORM

SHORT MEDICAL QUESTIONNAIRE

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

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.)

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

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 Y N	Dental Y N	☐ Male ☐ Female	Height	Weight	Marital Status S M	Smoker Y N

Application for HEALTH Coverage (check one): ☐ **Employee only** ☐ **Employee & Spouse** ☐ **Employee & Children** ☐ **Family**
Application for DENTAL 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	Dental Coverage	Marital Status	Gender	Social Security # (required for Federal reporting)	Birth Date Mo./Day/Yr.	Height	Weight	Smoker
Spouse		☐ Y ☐ N	☐ Y ☐ N		M ☐ F ☐					☐ Y ☐ N
		☐ Y ☐ N	☐ Y ☐ N		M ☐ F ☐					☐ Y ☐ N
		☐ Y ☐ N	☐ Y ☐ N		M ☐ F ☐					☐ Y ☐ N
		☐ Y ☐ N	☐ Y ☐ N		M ☐ F ☐					☐ Y ☐ N
		☐ Y ☐ N	☐ Y ☐ N		M ☐ F ☐					☐ Y ☐ N

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____________________
Dental 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____________________
Employer through which coverage is held____________________ ☐ Medicare Plan A (Hospital only) ☐ A & B (Hospital & Medical)

PLEASE COMPLETE REVERSE SIDE

THIS SECTION MUST BE COMPLETED

	Yes	No
1. In the past 5 years, have you or any of your dependents been treated or diagnosed with the following : (please check all that apply)	☐	☐

- ☐ heart disease
- ☐ arthritis
- ☐ respiratory illness
- ☐ diabetes
- ☐ cancer
- ☐ mental nervous disorder
- ☐ stroke
- ☐ alcohol or drug use
- ☐ muscular or systemic disease
- ☐ Acquired Immune Deficiency Syndrome (AIDS)
- ☐ liver, kidney or intestinal disorder
- ☐ AIDS Related Complex or other immune system disorder
- ☐ other, provide complete detail below

	Yes	No
2. Have you or any dependent been advised in the last 12 months that hospitalization, surgery, or treatment is needed or pending? Describe below.	☐	☐
3. In the past 5 years, have you or any dependent been treated by a physician for medical complications other than routine care of physcial check-ups? Describe below.	☐	☐
4. Are you or any dependent currently pregnant? Provide due date below.	☐	☐
5. Do you or any dependent regularly take any medication, prescribed or other? Provide list of medications below.	☐	☐

"YES" answers to any part of questions 1, 2, 3, 4 or 5 are to be explained below. Please give complete details.
If additional space is needed, please use another sheet of paper.

Question # and Name of Person	Diagnosis, treatment or reason for physical check-up	Date of treatment, length of hospital stay and degree of recovery	Doctor's name and phone number

REFUSAL OF COVERAGE
I have decided not to apply for Coverage for: **MEDICAL:** ☐ **Employee** ☐ **Children** ☐ **Spouse** **DENTAL:** ☐ **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 REALIZE THAT FALSE INFORMATION OR OMISSIONS IN THIS FORM WILL RESULT IN CANCELLATION OF COVERAGE AND MAY BE GROUNDS FOR THE PLAN TO COLLECT DAMAGES.

EMPLOYEE SIGNATURE:______________________________ Date:______________
(Signature is required even if refusing coverage)

SPOUSE SIGNATURE:______________________________ Date:______________
(Signature is required even if refusing coverage)

EMPLOYER SIGNATURE:______________________________ Date:______________

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

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