MEMBER ENROLLMENT FORM

ALL INFORMATION MUST BE PROVIDED, PLEASE PRINT IN INK OR TYPE

SECTION 1: SUBSCRIBER INFORMATION

NAME	GENDER ☐ MALE ☐ FEMALE	EMPLOYER NAME
STREET ADDRESS	HOME PHONE WORK PHONE	DIVISION / SUB GROUP
CITY, STATE, ZIP CODE	SOCIAL SECURITY NO.	DATE OF HIRE
EMPLOYMENT STATUS : ☐ FULL-TIME ☐ PART-TIME ☐ RETIRED ☐ COBRA ☐ SALARIED ☐ IF HOURLY-# HOURS WORKED WKLY ________	MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ LEGALLY SEPARATED ☐ DOMESTIC PARTNER	DATE OF BIRTH DATE COVERAGE EFFECTIVE

SECTION 2: ENROLLMENT CHOICES

WAIVING COVERAGE (Check box that best describes situation resulting from coverage waiver):

☐ I AM DECLINING ENROLLMENT, **I DO** HAVE COVERAGE THROUGH SPOUSE, OR ELSEWHERE

☐ I AM DECLINING ENROLLMENT, **I DO NOT** HAVE COVERAGE ELSEWHERE

COVERAGE TYPE: ☐ EMPLOYEE ☐ EMPLOYEE & SPOUSE ☐ EMPLOYEE & CHILD ☐ FAMILY

PLAN TYPE:	**SIGNATURE PLANS:**		**SIGNATURE PLUS PLAN: (DENTAL OPTION)**		**STANDARD PLANS :**
DEDUCTIBLE I:	☐ $1,200/$2,400	DEDUCTIBLE I:	☐ $1,200/$2,400	DEDUCTIBLE I:	☐ $500/$1000
DEDUCTIBLE II:	☐ $2,500/$5,000	DEDUCTIBLE II:	☐ $2,500/$5,000	DEDUCTIBLE II:	☐ $1000/$2,000
DEDUCTIBLE III:	☐ $5,000/$10,000	DEDUCTIBLE III:	☐ $5,000/$10,000		

SECTION 3: DEPENDENT INFORMATION

DEPENDENT NAME (Last, First, MI)	NAME OF PCP	RELATIONSHIP	DATE OF BIRTH	GENDER	STATUS
		☐ SPOUSE			☐ DATE OF MARRIAGE ☐ DATE OF DIVORCE
		☐ CHILD ☐ STEP-CHILD			☐ FULL-TIME STUDENT ☐ HANDICAPPED/DISABLED
		☐ CHILD ☐ STEP-CHILD			☐ FULL-TIME STUDENT ☐ HANDICAPPED/DISABLED
		☐ CHILD ☐ STEP-CHILD			☐ FULL-TIME STUDENT ☐ HANDICAPPED/DISABLED
		☐ CHILD ☐ STEP-CHILD			☐ FULL-TIME STUDENT ☐ HANDICAPPED/DISABLED

Who is legally responsible for stepchildren's medical bills? ______________________________

For dependents over 19, you must provide name of school and expected graduation date: ______________________________

SECTION 4: SPOUSE EMPLOYER INFORMATION:

If spouse is employed, give Name and Address of employer: ______________________________

Does spouse's employer offer medical or dental coverage? ☐ YES ☐ NO

SECTION 5: OTHER INSURANCE

Are you and/or your dependents covered under another health or dental insurance plan (including Medicare or Medicaid)? ☐ YES ☐ NO

If yes, please provide the following information and attach a copy of the plan's ID card in order to assure accurate and timely processing of your claims.

HEALTH INSURANCE CO. NAME & ADDRESS			DENTAL INSURANCE CO. NAME & ADDRESS		
POLICYHOLDER NAME	POLICY NUMBER	GROUP POLICY	POLICYHOLDER NAME	POLICY NUMBER	GROUP NUMBER
EFFECTIVE DATE	TYPE OF COVERAGE ☐ SINGLE ☐ 2 PERSON ☐ FAMILY		EFFECTIVE DATE	TYPE OF COVERAGE ☐ SINGLE ☐ 2 PERSON ☐ FAMILY	

SECTION 6: HIPAA COMPLIANCE

Will this plan replace existing health insurance coverage? ☐ YES ☐ NO

If yes, please attach to this form a certificate of prior health insurance coverage. Your prior insurer will give you this form.

SECTION 7: SIGNATURE

I represent that the statements on this benefit enrollment and change form and all information furnished by me are true and complete to the best of my knowledge. I authorize any healthcare provider to disclose to Patriot Health Insurance Company Inc., or its designated agent, any information acquired in connection with my past or future care or treatment or that of any dependent named herein or hereafter added to my coverage.

Subscriber's Signature	Date