

Enrollment Form

Application for: <input type="checkbox"/> Medical <input type="checkbox"/> Delta Dental <input type="checkbox"/> Life/AD&D <input type="checkbox"/> Delta Vision Disability: <input type="checkbox"/> Short term <input type="checkbox"/> Long Term	Waiver of Coverage: I decline coverage for: <input type="checkbox"/> Employee & all dependents <input type="checkbox"/> Spouse only <input type="checkbox"/> Dependents only Reason: <input type="checkbox"/> Covered under another health plan <input type="checkbox"/> Other (specify): _____
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A. Employee & Family Information

Employee's Last Name		First Name		Middle Initial	Social Security Number	
Street Address			PO Box	Apt. No.	City	State Zip
Home Phone ()		Work Phone ()		Email (if available)		Disability (optional)
Date of Birth	Gender	Ethnicity (optional)	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated		Have you previously been covered by PHP? Y / N	
Independent Contractor? <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary Care Physician Last Name/First Initial		Current Patient? Y / N	Language preference	

Please list family members to be covered under this policy. Please attach additional form if needed. Write name as it should appear on ID Card. If dependent is age 19 or over and is an IRS dependent, please indicate the relationship of the dependent and "IRS".

	First Name	M.I.	Last Name	Social Security Number	Relationship	Gender	Date of Birth	Age 19 & over Full-time Student?	Primary Care Physician First & Last Name	Current Patient?
1								Y / N School Name:		Y / N
2								Y / N School Name:		Y / N
3								Y / N School Name:		Y / N
4								Y / N School Name:		Y / N

B. Coordination of Benefits – (Failure to complete this section may result in delays in enrollment or claim payments)

On the day your coverage begins, will any family members above be covered by other medical, dental or Medicare insurance?
 No Yes **If yes, please complete this section and attach a copy of the card.** Please use extra paper if more than one additional policy will be in force.

Coverage type (please attach copy of other medical insurance card): <input type="checkbox"/> Medical Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Dental Insurance		Name of Policy Holder		Policy Holder Date of Birth	
Insurance Company Name & Phone Number			Policy Number		Policy Holder's Employer
Medicare Policy Number		Medicare Part A Effective Date		Medicare Part B Effective Date	
Medicare Part D Effective Date		Reason for Medicare: <input type="checkbox"/> End Stage Renal Disease <input type="checkbox"/> Disability <input type="checkbox"/> Over age 65 <input type="checkbox"/> Over age 65 and working			Please list everyone covered by other insurance:
					Coverage Dates:

C. Employee Signature – this form must be signed by the employee even if waiving coverage.

ACCURACY OF INFORMATION: On behalf of myself and anyone enrolled on or added to this application ("Us"), I understand and agree that any omissions or incorrect statements knowingly made by Us on this application may invalidate my and/or my dependents' coverage. **NOTICE OF ENROLLMENT RIGHTS:** I understand that if I decline enrollment for myself or my dependents (including my spouse) because of other health coverage, I may be able to enroll myself and my dependents in this policy if I or my dependents lose eligibility for that other coverage (or if the employer stops contributing towards my or my dependents' other coverage). However, I must request enrollment within 30 days after my or my dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, I understand that if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents. However, I must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. To request special enrollment or obtain more information, I can contact PHPMM at 517.364.8500.

Employee Signature _____ Date Signed _____

D. For Employer Use only

Group Name	Group Number	Sub Group Number	Class Number	Effective Date
Qualifying event date:	Qualifying event reason: <input type="checkbox"/> New Hire <input type="checkbox"/> Return <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Status Change <input type="checkbox"/> Other	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	<input type="checkbox"/> Union <input type="checkbox"/> Non Union	<input type="checkbox"/> Salaried <input type="checkbox"/> Hourly

Employer Representative Printed Name: _____

Employer Representative Signature (required): _____ Date Signed: _____

For Plan Use Only Subscriber ID: _____ Entered by: _____ Dept: _____ Date Entered: _____

Eligibility Level/Family Indicator: _____ Notes: _____

Send completed forms to:
PHPMM, PO Box 399,
Linthicum, MD, 21090-0399
Or Fax to: (517) 364-8280

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