AmeriHealth ADMINISTRATORS

APPLICATION FOR GROUP ENROLLMENT OR CHANGE

Effective Date of Action ☐☐ ☐☐ ☐☐☐☐

Please type or print all data clearly. If any data is missing or illegible, we must delay your enrollment until we receive a complete application.

1. Subscriber Information – Please complete this entire section, whether you are a new applicant or are making a change to an existing contract.

Social Security Number or ID Number | Last Name | First Name | M.I. | Gender ☐ Male ☐ Female

Street Address | Apartment or Suite | City | State | Zip Code

Telephone Number including Area Code

Home

Work

Cell

Are you actively at work? ☐ Yes ☐ No

If no, please explain. ____________

Date of Hire

Hours worked per week

Date of Birth

Title ____________

email

Marital Status

☐ Single ☐ Married

☐ Domestic Partnership - Same Sex

☐ Domestic Partnership - Opposite Sex

☐ Divorced ☐ Separated ☐ Widowed

2A. Plan Selection – Please select only coverages offered by your Plan Sponsor.

Medical

☒ PPO — Benefit ID Number 3 3 2 8 0 8

☐ CMM ____

☐ Closed Panel PPO

☒ Rx — Benefit ID Number 3 3 2 8 0 9

☐ ~~Dental~~ — Benefit ID Number N / A

☐ ~~Vision~~ — Benefit ID Number N / A

☐ ~~DCA~~

☒ HRA

☐ ~~HSA~~

☐ ~~FSA~~

☐ Decline all coverage

2B. Coverage Information

Persons to be covered by this plan:

☐ Employee only

☐ Employee and Spouse

☐ Employee and Domestic Partner

☐ Employee, Spouse, and Child(ren)

☐ Employee and Child(ren)

3. Dependent Information – Please provide all information for each person to be covered. Please attach additional sheets if required.

Spouse/Domestic Partner Last Name | First Name | M.I. | Gender | Date of Birth | Social Security Number

Will other health insurance be in effect? Is Yes, see 4. ☐ Yes ☐ No

Child Last Name | First Name | M.I. | Gender | Date of Birth | Social Security Number

Will other health insurance be in effect? Is Yes, see 4. ☐ Yes ☐ No Dependent over 26? ☐ Student ☐ Disabled Provide verification.

Child Last Name | First Name | M.I. | Gender | Date of Birth | Social Security Number

Will other health insurance be in effect? Is Yes, see 4. ☐ Yes ☐ No Dependent over 26? ☐ Student ☐ Disabled Provide verification.

Child Last Name | First Name | M.I. | Gender | Date of Birth | Social Security Number

Will other health insurance be in effect? Is Yes, see 4. ☐ Yes ☐ No Dependent over 26? ☐ Student ☐ Disabled Provide verification.

Child Last Name | First Name | M.I. | Gender | Date of Birth | Social Security Number

Will other health insurance be in effect? Is Yes, see 4. ☐ Yes ☐ No Dependent over 26? ☐ Student ☐ Disabled Provide verification.

4. Other Coverage Information

List health insurance information for you or any dependents with other coverage.

Carrier Name

Policy Holder

Policy Number _____ **Type of benefits** _____

Indicate whether any person to be covered is enrolled under Medicare Part A or B.

Name	Medicare Number	
		☐ Part A ☐ Part B
		☐ Part A ☐ Part B
		☐ Part A ☐ Part B

5. Acknowledgment and Signature

IMPORTANT INFORMATION ABOUT THIS APPLICATION

If you are applying for coverage that you are entitled to now or that you may become entitled to through your group health plan
When you sign below, you confirm that you understand that your coverage will start only after the Plan approves your application. If you leave out any information or if anything is unclear, we will contact you.

Your coverage will start after we receive all the necessary information. This coverage will be valid only if the statements that you make on this application are true and complete to the best of your knowledge.

You authorize the Plan and its agents to recover, collect, compromise, or sue in your name, or your enrolled dependent's name, for the amount of damages sustained. But the Plan is not required to do so.

Notice about fraudulent information
Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

If you decline coverage for yourself or your eligible dependents
When you sign below, you confirm that:

1. You understand that you are eligible for coverage under your employer's or organization's Plan.
2. You understand the coverage offered through the Plan.
3. You decline coverage for yourself or your eligible dependents.
4. You give up all claims to coverage under this Plan.
5. You understand that if you request coverage for yourself or your dependents in the future, you may not be offered coverage, except as allowed during a special enrollment period.

Special Enrollment Period
Other health coverage. If you do not enroll yourself or your dependents (including your spouse) now because you have other health coverage, you may be able to enroll yourself or your dependents in this Plan if your other coverage ends. You must ask to enroll within 30 days after your other coverage ends.

New dependent. If you have a new dependent due to marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, as long as you request enrollment within 30 days after the event.

I have read and understand the "Important information about this application" section. I authorize any physician, hospital, pharmacy, employer, insurer, or other party to allow AmeriHealth Administrators, Inc. or their representatives, to view or receive copy or details of any medical data they have about me or my dependents, as needed to determine eligibility for benefits. I understand this information cannot be disclosed without my authorization. A copy of this authorization is as valid as the original. I hereby request the amount(s) of coverage for which I may become eligible. I authorize payroll deductions to pay my share of contributions, if any, when my coverage takes effect. I can revoke this authorization with written notice to my employer.

Employee Signature (REQUIRED) _____ **Date** _____

6. Group and Employer Information – Your Group Administrator MUST complete this section. Your application CANNOT be processed unless this section is complete.

Account Name	Account Number	Subaccount Number (if applicable)	Payroll/Work Location
City of Hibbing	019829	019834	AG00216 1

NEW
- ☐ New Hire
- ☐ Open Enrollment
- ☐ Waive Coverage

CHANGE
- ☐ Address
- ☐ Name
- ☐ Rehire
- ☐ Life Event
- ☐ Benefit ID
- ☐ Add a Dependent
- ☐ Delete a Dependent
- ☐ Return from Layoff
- ☐ Sub account
- ☐ Account

LIFE EVENT CHANGE
- ☐ Marriage
- ☐ Newborn
- ☐ Loss of Health Coverage
- ☐ Divorce or Legal Separation

Life Event Date _____

OTHER CHANGE
- ☐ COBRA

Effective Date _____

Effective Date of Coverage

TERMINATE CONTRACT
- ☐ Terminated Employment
- ☐ Full Time to Part Time
- ☐ Deceased. Date _____
- ☐ Other. Please explain.

_____

Employer or Group Administrator Signature (REQUIRED) _____ **Date** _____

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