

PPO/INDEMNITY ENROLLMENT CHANGE OF STATUS FORM

Changes must be received within 31 days of the event



1231 East Beltline NE MS 2170
Grand Rapids, MI 49525

I am completing this form for: (check all that apply)

- Enrollment
- Termination
- Contract Change
- Name/Address Change
- Reinstatement
- COBRA

SECTION 1 - EMPLOYEE INFORMATION

Employee Last Name		First Name		Middle Initial	Social Security Number	
Street Address			City		State	Zip Code
Home Phone () - () - () - ()		Work Phone () - () - () - ()		Sex Male <input type="checkbox"/> Female <input type="checkbox"/>	Birth Date / /	
Marital Status Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/>				Employee covered by other insurance? (If yes, complete section 3) Yes <input type="checkbox"/> No <input type="checkbox"/>		

SECTION 2 - DEPENDENT INFORMATION

Please list spouse and/or dependents who will be covered under this policy (if you have more than 4 please complete an additional Enrollment Form). Dependents over the age of 19 must attach proof of full-time student status at an accredited institution of higher learning. Dependent covered by other insurance? (If YES, complete Section 3)

1 Spouse	Last Name		First Name		Middle	Sex Male <input type="checkbox"/> Female <input type="checkbox"/>	Birthdate / /	Yes <input type="checkbox"/>
	Social Security Number		No <input type="checkbox"/>					
2 Natural Child <input type="checkbox"/> Step Child <input type="checkbox"/>	Last Name		First Name		Middle	Sex Male <input type="checkbox"/> Female <input type="checkbox"/>	Birthdate / /	Yes <input type="checkbox"/>
	Social Security Number		No <input type="checkbox"/>					
3 Natural Child <input type="checkbox"/> Step Child <input type="checkbox"/>	Last Name		First Name		Middle	Sex Male <input type="checkbox"/> Female <input type="checkbox"/>	Birthdate / /	Yes <input type="checkbox"/>
	Social Security Number		No <input type="checkbox"/>					
4 Natural Child <input type="checkbox"/> Step Child <input type="checkbox"/>	Last Name		First Name		Middle	Sex Male <input type="checkbox"/> Female <input type="checkbox"/>	Birthdate / /	Yes <input type="checkbox"/>
	Social Security Number		No <input type="checkbox"/>					

SECTION 3 - OTHER INSURANCE INFORMATION

Are you, your spouse, or any dependents covered by Medicare or any other insurance policy providing benefits? Yes. Please complete this section No. Skip to Section 4

WHERE ARE CLAIMS SENT?	Insurance Company Name	Company Address		
POLICYHOLDER INFORMATION	Name of Policyholder	Birthdate / /	Policy Effective Date / /	Employer
	Family Member(s) Covered (1) (2) (3) (4)			
REASON FOR MEDICARE	Medicare Claim Number	End Stage Renal Disease <input type="checkbox"/>	Disabled <input type="checkbox"/>	Over Age 65 <input type="checkbox"/>
		Over Age 65 and Working <input type="checkbox"/>	Effective Date / /	

SECTION 4 - REFUSAL OF COVERAGE (IF APPLICABLE)

REFUSAL OF COVERAGE (IF APPLICABLE):
I hereby certify that I have been offered coverage under the Benefit Plan(s) sponsored by my Employer, and have decided NOT to take advantage of this offer. If I request to add coverage at a later date, I will be subject to the terms and limitations as described in the Summary Plan Description.

COVERAGE REFUSED:

- Medical Coverage for Myself
- Medical Coverage for my Eligible Dependents
- Dental Coverage for Myself
- Dental Coverage for my Eligible Dependents
- Vision Coverage for Myself
- Vision Coverage for my Eligible Dependents
- Other _____
- Other _____

Employee Signature: _____ Date: _____

SECTION 5 - AUTHORIZATION

I apply for coverage for each person listed above and agree that we will abide by the Employer Summary Plan Description. I authorize any person or entity involved in my medical care or having information regarding my medical care to release information to Priority Health or the Plan Administrator. I authorize Priority Health to release such information, as necessary, to insurance companies, The Plan Administrator, reinsurance companies, organizations performing services in connection with my claim, or as may be otherwise lawfully required, or as I may further authorize. I have the right to request a copy of this information and agree that photocopies of this authorization will be valid.

Employee Signature: _____ Date: _____

Employer: PLEASE COMPLETE THIS SECTION	Company Name		Department Code/Location			
	Company Representative Signature			Date / /		
	Group Number		Date of Hire / /	Effective Date / /		
	PLEASE CHECK ALL APPLICABLE BOXES:	TYPE Union <input type="checkbox"/> Non-Union <input type="checkbox"/> Salary <input type="checkbox"/> Hourly <input type="checkbox"/> Cobra <input type="checkbox"/>		RETIREE Early Retiree (Under 65) <input type="checkbox"/> Retiree (65+) <input type="checkbox"/>		
		REASON New Hire <input type="checkbox"/> New Group <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Special Enrollment <input type="checkbox"/> Reason _____				
COVERAGE (AS APPLICABLE):	HEALTH PPO <input type="checkbox"/> INDEMNITY <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/>		DENTAL SINGLE <input type="checkbox"/> FAMILY <input type="checkbox"/>			
	HEALTH OPTION (IF APPLICABLE) OPTION A <input type="checkbox"/> OPTION B <input type="checkbox"/>		VISION SINGLE <input type="checkbox"/> FAMILY <input type="checkbox"/>			
	LIFE Life Amount \$ _____ AD&D \$ _____ Short Term Disability \$ _____					
CHANGES	REASON FOR ADDITIONS Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Child by Legal Adoption/Guardianship (Attach copy of Court Form) <input type="checkbox"/> Stepchild <input type="checkbox"/> Other <input type="checkbox"/>			Date Coverage Began / /		
	REASON FOR DELETIONS Marriage of Dependent <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Lost Eligibility <input type="checkbox"/> Other <input type="checkbox"/>			Date Coverage Ended / /		
	REASON FOR TERMINATION OF ENTIRE CONTRACT Voluntary Termination of Employment <input type="checkbox"/> Lay Off <input type="checkbox"/> Involuntary Termination of Employment <input type="checkbox"/>			Date Occurred / /	Date Coverage Ended / /	
	Leave of Absence <input type="checkbox"/> Deceased <input type="checkbox"/> COBRA Terminated <input type="checkbox"/> Changed Health Plans <input type="checkbox"/> Other <input type="checkbox"/>					
	COBRA CONTINUATION 18 Month <input type="checkbox"/> 29 Month <input type="checkbox"/> 36 Month <input type="checkbox"/>			Qualifying Event Date / /	Loss of Coverage Date / /	

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Marital Status Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/>	Employee covered by other insurance? (If yes, complete section 3) Yes <input type="checkbox"/> No <input type="checkbox"/>			

SECTION 2 - DEPENDENT INFORMATION

Please list spouse and/or dependents who will be covered under this policy (if you have more than 4 please complete an additional Enrollment Form). Dependents over the age of 19 must attach proof of full-time student status at an accredited institution of higher learning.

	Last Name	First Name	Middle	Sex Male <input type="checkbox"/> Female <input type="checkbox"/>	Birthdate / /	Dependent covered by other insurance? (If YES, complete Section 3)
1 Spouse						Yes <input type="checkbox"/> No <input type="checkbox"/>
	Social Security Number					
2 Natural Child <input type="checkbox"/> Step Child <input type="checkbox"/>						Yes <input type="checkbox"/> No <input type="checkbox"/>
	Social Security Number					
3 Natural Child <input type="checkbox"/> Step Child <input type="checkbox"/>						Yes <input type="checkbox"/> No <input type="checkbox"/>
	Social Security Number					
4 Natural Child <input type="checkbox"/> Step Child <input type="checkbox"/>						Yes <input type="checkbox"/> No <input type="checkbox"/>
	Social Security Number					

SECTION 3 - OTHER INSURANCE INFORMATION

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REASON FOR MEDICARE	Medicare Claim Number	End Stage Renal Disease <input type="checkbox"/> Disabled <input type="checkbox"/> Over Age 65 <input type="checkbox"/> Over Age 65 and Working <input type="checkbox"/>	Effective Date / /	

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COVERAGE REFUSED: Medical Coverage for Myself Medical Coverage for my Eligible Dependents
 Dental Coverage for Myself Dental Coverage for my Eligible Dependents
 Vision Coverage for Myself Vision Coverage for my Eligible Dependents
 Other _____ Other _____

Employee Signature: _____ Date: _____

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Employee Signature: _____ Date: _____

Employer: PLEASE COMPLETE THIS SECTION	Company Name	Department Code/Location	
	Company Representative Signature	Date / /	
	Group Number	Date of Hire / /	Effective Date / /
	PLEASE CHECK ALL APPLICABLE BOXES:	TYPE Union <input type="checkbox"/> Non-Union <input type="checkbox"/> Salary <input type="checkbox"/> Hourly <input type="checkbox"/> Cobra <input type="checkbox"/>	RETIREE Early Retiree (Under 65) <input type="checkbox"/> Retiree (65+) <input type="checkbox"/>
		REASON New Hire <input type="checkbox"/> New Group <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Special Enrollment <input type="checkbox"/> Reason _____	
ENROLLMENT	COBRA CONTINUATION	Qualifying Event Date / /	COBRA Effective Date / /
	HEALTH PPO <input type="checkbox"/> INDEMNITY <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/>	DENTAL SINGLE <input type="checkbox"/> FAMILY <input type="checkbox"/>	
	HEALTH OPTION (IF APPLICABLE) OPTION A <input type="checkbox"/> OPTION B <input type="checkbox"/>	VISION SINGLE <input type="checkbox"/> FAMILY <input type="checkbox"/>	
	LIFE Life Amount \$ _____	AD&D \$ _____	Short Term Disability \$ _____
	CHANGES	REASON FOR ADDITIONS Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Child by Legal Adoption/Guardianship (Attach copy of Court Form) <input type="checkbox"/> Stepchild <input type="checkbox"/> Other <input type="checkbox"/> _____	Date Coverage Began / /
REASON FOR DELETIONS Marriage of Dependent <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Lost Eligibility <input type="checkbox"/> Other <input type="checkbox"/> _____		Date Coverage Ended / /	
REASON FOR TERMINATION OF ENTIRE CONTRACT Voluntary Termination of Employment <input type="checkbox"/> Lay Off <input type="checkbox"/> Involuntary Termination of Employment <input type="checkbox"/>		Date Occurred / /	Date Coverage Ended / /
Leave of Absence <input type="checkbox"/> Deceased <input type="checkbox"/> COBRA Terminated <input type="checkbox"/> Changed Health Plans <input type="checkbox"/> Other <input type="checkbox"/> _____			
COBRA CONTINUATION 18 Month <input type="checkbox"/> 29 Month <input type="checkbox"/> 36 Month <input type="checkbox"/>		Qualifying Event Date / /	Loss of Coverage Date / /

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