

# AmeriHealth Administrators

P.O. Box 21545  
Eagan, MN 55121

## APPLICATION FOR GROUP ENROLLMENT OR CHANGE

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.

**Be sure to read the back of this form.**

### 1 - CHECK OFF THE ACTION THAT YOU ARE REQUESTING.

Effective date of the action: ____/____/____	<input type="checkbox"/> New enrollment	<input type="checkbox"/> Info change	<input type="checkbox"/> Add dependent
	<input type="checkbox"/> Name/address change	<input type="checkbox"/> Cancel coverage	<input type="checkbox"/> Cancel dependent

If requesting a change, is it a result of a life event? <i>Check any that apply. Include documentation.</i>	Agreement #
<input type="checkbox"/> Marriage <input type="checkbox"/> Divorce or legal separation <input type="checkbox"/> Birth/adoption of child	
<input type="checkbox"/> Loss of spouse's health coverage    Date of life event: ____/____/____	

### 2 - EMPLOYEE INFORMATION

Employment Status: <input type="checkbox"/> Fulltime <input type="checkbox"/> Parttime <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> COBRA			
Employee's Last Name, First Name, M.I.	Group/Company/Division Name	Group #	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced

Address	Sex	Date of Birth / /	Social Security or HIC #*	Job Title
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City	State	Zip Code	Date of Hire / /	Date Transferred From HMO / /
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Enrolled in Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, include a copy of your Medicare ID card. State reason for entitlement: _____</i>	Home Phone (    ) _____
	Email address _____

If enrolled under COBRA: Date of qualifying event \_\_\_\_/\_\_\_\_/\_\_\_\_    Qualifying event: \_\_\_\_\_

### 3 - ELIGIBLE DEPENDENTS - LIST SPOUSE FIRST. (If you need more space, attach a sheet of paper.)

First Name, Middle Initial	Last Name (if it differs from employee's)	Relationship to Employee	Birth date	Sex	Social Security #* / Medicare(HIC) <i>Medicare Enrollees, include a copy of your ID card and state reason for entitlement.</i>
		<b>Spouse</b>			

\* We maintain this information as confidential. We do not use Social Security numbers as identification numbers.

### 4 - OTHER COVERAGE INFORMATION

Are you or any eligible family members currently covered by other group health coverage?     Yes     No

If you answered Yes above, check the appropriate boxes to show who is covered by the other coverage. Then complete the rest of Section 4.     Myself     My spouse     My dependent children

Name and Address of Other Coverage Carrier	To whom is the other coverage issued? <input type="checkbox"/> Myself <input type="checkbox"/> My spouse <input type="checkbox"/> Other
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Name and Address of Other Group	Spouse's Birth date / /
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### 5 - EMPLOYEE ELECTION AND SIGNATURE (Check all that apply.)

I **APPLY** for  Medical     Dental     Vision     Prescription coverage **FOR**  Myself     Myself & my dependents.

I **DECLINE**  Medical     Dental     Vision     Prescription coverage **FOR**  Myself     Dependents     Myself & dependents.

*I have read and understand the "Important Information About This Application" on the back of this form. 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 amounts 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's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**BE SURE TO READ THE BACK OF THIS FORM.**

## IMPORTANT INFORMATION ABOUT THIS APPLICATION

*Please read this information carefully. It refers to Section 5, "Employee Election and Signature," on the front of this form.*

### **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 Section 5 on the front of this form, you confirm that you understand that your coverage will start only after the Plan approves your application. If you leave out any information, we will contact you. We will also contact you if anything is unclear.

**Your coverage will start** after we receive all the needed 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.

**If you or any of your dependents received medical care or advice for a disease or physical condition** before your coverage starts and that person is over age 19:

- Care or advice for that condition *may* not be covered; or
- Your Plan *may* limit coverage until you or your dependent is covered by this Plan for a defined period. See your Summary Plan Description for this period.

This applies only to a disease or physical condition for which you or your dependent received: medical care; medication; or advice before your coverage started.

**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 Section 5 on the front of this form 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. (You checked these boxes in Section 5.)
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. This enrollment period is described below.

#### **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.

#### **Proof of application for health care benefits (temporary identification)**

If you see a health care provider before you get your ID card, you can bring a copy of this form. It shows that you applied for coverage through your group health plan. Section 5 shows if you applied for your dependents. ***However, this form does not guarantee coverage. Benefits will start only when the Plan approves your application.***