



# ENROLLMENT APPLICATION/CHANGE FORM

TO BE COMPLETED BY EMPLOYER

TO BE COMPLETED BY PLAN

|  |                                 |   |   |   |                                    |
|--|---------------------------------|---|---|---|------------------------------------|
| Employer Name<br><b>VANDERBURGH COUNTY</b> |                                 |   | Group #   | Plan Code   | Subscriber #                       |
| Effective Date Of Coverage<br>Mo Day Yr    | Date Of Employment<br>Mo Day Yr | Type of Enrollment:<br><input type="checkbox"/> Open Enrollment<br><input type="checkbox"/> COBRA | <input type="checkbox"/> New Hire<br><input type="checkbox"/> Retiree | <input type="checkbox"/> PLAN 1<br><input type="checkbox"/> PLAN 2<br><input type="checkbox"/> PLAN 3 | Location<br>Policy Type<br>Network |

## CHANGE IN STATUS FOR EMPLOYEE & DEPENDENT FAMILY MEMBERS

Adding dependent (list name(s) below)

Marriage  
 Birth  
 Adoption (attach adoption decree)  
 New student (attach current class schedule)  
 Address change (list new address below)  
 COBRA coverage (list name(s) below)  
 Original COBRA effective date \_\_\_\_\_  
 Conversion (list name(s) below)  
 Other

**EFFECTIVE DATE OF CHANGE** Mo Day Yr

Name change  
Previous name \_\_\_\_\_  
Current name \_\_\_\_\_

Deleting dependent(s) (list here with reason):  
\_\_\_\_\_

Termination of employee coverage (check reason below)  
 Left employment  
 Moved out of area  
 Payroll deduction too high  
 Other Insurance  
 Other reason (list here)

Social Security No. \_\_\_\_\_ Employee's Last Name First Middle \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Date of Birth Mo Day Yr \_\_\_\_\_ Sex  Male  Female

Marital Status  Single  Widowed  Married  Divorced

\*By giving my e-mail address I authorize WHP to electronically send newsletters and other communication regarding my account via this Internet address.

## EMPLOYEE & DEPENDENT FAMILY MEMBERS TO BE COVERED BY THE HEALTH PLAN

employee  
spouse  
dependent  
dependent  
dependent

| Name<br>(if last name different, please list full name.) | Date of Birth<br>Mo Day Yr | Sex  | Relationship<br>to Employee | Primary Care Physician<br>Select One for Each Family Member | Have you been<br>treated by<br>this physician?              | Is dependent<br>a full-time<br>student?<br>If Yes, attach required verification. | Is<br>dependent<br>disabled?                                |
|--|----------------------------|--|-----------------------------|---|---|--|---|
|  |                            | <input type="checkbox"/> M<br><input type="checkbox"/> F | Employee                    |   | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No                      | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| SS No. _____   |                            | <input type="checkbox"/> M<br><input type="checkbox"/> F | Spouse                      |   | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No                      | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| SS No. _____   |                            | <input type="checkbox"/> M<br><input type="checkbox"/> F |                             |   | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No                      | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| SS No. _____   |                            | <input type="checkbox"/> M<br><input type="checkbox"/> F |                             |   | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No                      | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| SS No. _____   |                            | <input type="checkbox"/> M<br><input type="checkbox"/> F |                             |   | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No                      | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |

## ADDITIONAL COVERAGE INFORMATION - Must Be Completed if Adding Any Dependents

Are you, spouse, natural or stepchildren covered by another medical insurance plan?  Yes  No If yes, please complete the following information:

Is spouse employed?  Yes  No If yes, spouse's employer: \_\_\_\_\_  
Does spouse have medical coverage through employer?  Yes  No

Policyholder's Name \_\_\_\_\_ Policyholder's Date of Birth Mo Day Yr \_\_\_\_\_ Policyholder's Social Security \_\_\_\_\_ Policyholder's Employer \_\_\_\_\_ Policyholder's Work Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_ List Family Members Covered Under This Policy \_\_\_\_\_ Relationship To Policyholder \_\_\_\_\_

Policy Number \_\_\_\_\_

Are you covered under Medicare?  Yes  No If yes, list Medicare No. \_\_\_\_\_ Part A Effective Date: \_\_\_\_\_ Part B Effective Date: \_\_\_\_\_

Is your spouse covered under Medicare?  Yes  No If yes, list Medicare No. \_\_\_\_\_ Part A Effective Date: \_\_\_\_\_ Part B Effective Date: \_\_\_\_\_

I understand that WHP may collect personal information about me from outside sources, and that both personal and privileged information may be collected and disclosed to outside parties without my authorization as permitted by law. By signing this Enrollment Form, I agree to abide by all of the terms, conditions, rights and responsibilities as defined in the WHP Member Handbook and Agreement.

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_ Approval \_\_\_\_\_ Date \_\_\_\_\_