

**CUSTOMER SERVICE
PHONE NUMBER**
Toll-free: 1-888-747-7823

PPO ENROLLMENT FORM
Please complete this application in full, including your signature.
Use blue or black ink only and be sure all copies are printed legibly.



ENROLLEE INFORMATION <small>(please print clearly)</small>	Last Name:		First Name:				M.I.:		Social Security Number:			
	COMPLETE HOME ADDRESS		Street:			City:		State:		ZIP Code:		
	<input type="checkbox"/> Single (S) <input type="checkbox"/> Married (M) <input type="checkbox"/> Widowed (W) <input type="checkbox"/> Separated (L) <input type="checkbox"/> Divorced (D) <input type="checkbox"/> Other (O)						Home Phone: () ()		Business Phone: () ()			
EMPLOYMENT INFORMATION	Check box if you are actively employed <input type="checkbox"/>				Union Affiliation:		Average Number of Hours Worked Per Week:					
	Check box if you are retired <input type="checkbox"/>						<input type="checkbox"/> Under 20 Hours <input type="checkbox"/> 20-24 Hours <input type="checkbox"/> 25-29 Hours <input type="checkbox"/> 30+ Hours					
OTHER HEALTH COVERAGE INFORMATION	Will you be covered by another health plan when PHS ICT coverage starts?		If yes, list name and address of other carrier:				Spouse's Social Security Number:					
	<input type="checkbox"/> Yes <input type="checkbox"/> No											
	Is your spouse employed?		If yes, list employer's name and address:				Spouse's Daytime Phone Number:					
	<input type="checkbox"/> Yes <input type="checkbox"/> No						MO DAY YR Spouse's Date of Birth: / /					
	Will your spouse be covered by another health plan when PHS ICT coverage starts?		If yes, list name and address of other carrier:				Policy/Contract #:					
	<input type="checkbox"/> Yes <input type="checkbox"/> No											
	Will your dependents be covered by another health plan when PHS ICT coverage starts?		If yes, list name and address of other carrier:				Policy/Contract #:					
	<input type="checkbox"/> Yes <input type="checkbox"/> No											
MEDICARE INFORMATION	Are you covered by Medicare?		Medicare #:				Effective Dates: Part A Part B					
	<input type="checkbox"/> Yes <input type="checkbox"/> No											
	Is your spouse covered by Medicare?		Medicare #:				Effective Dates: Part A Part B					
	<input type="checkbox"/> Yes <input type="checkbox"/> No											
	Are other dependents covered by Medicare?		Name(s): Medicare #:				Effective Dates: Part A Part B					
	<input type="checkbox"/> Yes <input type="checkbox"/> No											
STUDENT INFORMATION	If dependent children listed are age 19 or older, do they attend school on a full-time basis?			If yes, list first name of child and school					If no, is the dependent child disabled?			
	<input type="checkbox"/> Yes <input type="checkbox"/> No								<input type="checkbox"/> Yes <input type="checkbox"/> No			

List yourself and any eligible dependents to be covered. Attach extra sheet if necessary.

	Last Name	First Name	M.I.	Social Security #	Sex:	Date of Birth			
					M/F	MO	DAY	YR	
Self									
Spouse									
Child									
Child									
Child									

Please attach a copy of the certificate of credible coverage, if any, for each person listed.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty.

AGREEMENT (please sign and date): I understand the PHS Insurance of Connecticut, Inc. (PHS ICT) benefits and coverage as summarized in the PHS ICT plan materials and that these benefits are administered strictly as specified in the PHS ICT plan documents.

I authorize any physician, hospital, insurer or other organization or person having any records or information concerning the health and treatment (including psychiatric, substance abuse, and confidential HIV related information) of me and my family member(s) to furnish such records as may be requested by PHS ICT, or its authorized representative for purposes relating to coverage. A photocopy or digital image of this authorization shall be considered as valid as the original. This authorization shall renew upon any subsequent renewal of coverage under this policy.

I certify that all dependents listed above are eligible for coverage under the terms of the PHS ICT plan documents. I agree to notify PHS ICT and my employer within 31 days when such eligibility ceases. I understand that PHS ICT is not liable to provide coverage to ineligible dependents.

If I am required to contribute, I authorize my employer to deduct from my wage the amount required for the coverage selected. I certify that all the information above is correct to the best of my knowledge.

Signature				Date			
HEALTH INFORMATION: I acknowledge that health care providers may disclose health information about me or my dependents, including information regarding substance abuse or mental/emotional conditions, to Health Net. The plans use and disclose this information for purposes of treatment, payment and health plan operations, including but not limited to utilization management, quality improvement, disease or case management programs.							
TO BE COMPLETED BY EMPLOYER	Name of employer or employing office:		Reason for Enrollment:		MO	DAY	YR
			<input type="checkbox"/> New Hire Date of Hire: / / <input type="checkbox"/> COBRA Enrollment <input type="checkbox"/> 18 months <input type="checkbox"/> 36 months Date of Elig: <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Other _____		Effective Date of Coverage:	Group #:	Subgroup:
							Plan Code:
Company Signature				Date			