

# Pre-65 Enrollment/Change Form



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| <input type="checkbox"/> Enroll<br><input type="checkbox"/> Cancel    Date: ___/___/___<br><input type="checkbox"/> Change<br><input type="checkbox"/> Name/Address Change |
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## Email Address:

<b>Social Security Number</b>	<b>Name (last) (first)</b>	<b>Date of Birth</b> ___/___/___	<b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female
<b>Address (street, PO Box)</b>	<b>City</b>	<b>State</b>	<b>Zip</b>
<b>Home Phone</b> ( )		<b>Marital Status</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	

## DEPENDENT INFORMATION

Last Name	First Name	MI	Gender	Relationship	Birth Date	Social Security Number
			M F	Spouse		
			M F	Child Stepchild		
			M F	Child Stepchild		
			M F	Child Stepchild		
			M F	Child Stepchild		

## COVERAGE SELECTION-MEDICAL

- \$900 Deductible Plan
- \$2,000 Deductible Plan
- \$3,500 Deductible Plan

- Employee Only
- Employee & Spouse
- Employee & Child(ren)
- Family
- Decline Medical Coverage

## COVERAGE SELECTION – DENTAL

- Dental

- Employee Only
- Employee & Spouse
- Employee & Child(ren)
- Family
- Decline Dental Coverage

## CHANGE SECTION:

- Cancel Medical
- Cancel Dental

## OTHER MEDICAL COVERAGE INFORMATION

On the day this coverage begins, will you, your spouse or any dependents be covered under any other medical health plan or policy, including another health plan or Medicare?  No (skip the rest of this section)  Yes (continue completing this section)

- Name of Other Insurance Carrier \_\_\_\_\_
- Spouse's employer's plan     Tri-Care
- Individual plan                       Medicare
- VA eligibility                         Medicaid
- COBRA                                 I(we) have no other coverage     Other \_\_\_\_\_

**If Medicare:** Name of Beneficiary \_\_\_\_\_

Medicare HIC# \_\_\_\_\_ Part A Effective Date: \_\_\_/\_\_\_/\_\_\_ Part B Effective Date \_\_\_/\_\_\_/\_\_\_

Reason for entitlement (check all applicable boxes)  Age  Disability  End stage renal disease

**OTHER DENTAL COVERAGE INFORMATION**

On the day this coverage begins, will you, your spouse or any dependents be covered under any other dental plan or policy?

- Yes (continue completing this section)     No (skip the rest of this section)
- Name of Other Insurance Carrier \_\_\_\_\_
- Spouse's employer's plan
- Individual plan
- I (we) have no other coverage     Other \_\_\_\_\_

**AGREEMENT AND AUTHORIZATION  
PLEASE READ THE FOLLOWING CAREFULLY**

I represent the above information to be complete and accurate to the best of my knowledge. I understand that my answers to the questions contained in this enrollment form will be used to determine eligibility for coverage. I further understand that if any material information is omitted, it could provide the basis to refuse or rescind coverage.

I agree to the following terms for myself and anyone enrolled on or added to this application: We authorize, if permitted by law, health care providers, insurers, claim administrators and employers to provide medical, employment and benefit information, including information relating to drug, alcohol or psychiatric histories and treatment, to the insurance carrier on this enrollment form or their authorized representatives. Insurance carriers or their authorized representatives may share in such information and provide it to their insurers, claim administrators, insurers or other provider organizations only for the purpose of administering group coverage and claims for benefits, utilization review, analytical or research purposes, risk management, provider peer review or the resolution of grievances. I also authorize on behalf of myself and anyone enrolled or added to this application the use of Social Security Numbers for purposes of identification. I agree that a reproduced copy of this authorization will be as valid as the original.

**I HAVE READ AND AGREE TO THE STATEMENTS ABOVE  
(SIGNATURE REQUIRED BELOW)**

X \_\_\_\_\_ X \_\_\_\_\_  
Signature Date Signed

**WAIVER/DECLINE COVERAGE:**

X \_\_\_\_\_ X \_\_\_\_\_  
Signature Date Signed

**I have been given the opportunity to apply for group health coverage for myself and my dependents (if applicable)**

If you are waiving/declining coverage for yourself or your dependents (including your spouse) because of other coverage, you or your dependents will not be able to enroll in the plan at a later time.