



**Enrollment**  
 **Add Dependents Form**  
**CONFIDENTIAL ENROLLMENT INFORMATION**

Employer Name: \_\_\_\_\_  
 Group #: \_\_\_\_\_

Effective Date of Coverage: \_\_\_\_\_  
 Please Complete and Return to Human Resources

1. Coverage Selection	2. Waiver of Coverage
<p>Medical (Please select one)</p> <p><b>HMO</b></p> <p><input type="checkbox"/> Community Gold</p> <p><input type="checkbox"/> Community Choice</p> <p><input type="checkbox"/> POS-2</p> <p><input type="checkbox"/> Other _____</p> <p><b>PPO</b></p> <p><input type="checkbox"/> Select Choice</p> <p><input type="checkbox"/> Quality Choice</p> <p><input type="checkbox"/> HSA-Eligible High Deductible Health Plan (HDHP)</p>	<p>Must complete to waive medical coverage</p> <p>I decline to enroll coverage for:</p> <p><input type="checkbox"/> Myself                      <input type="checkbox"/> Existence of other group health coverage</p> <p><input type="checkbox"/> My spouse                  <input type="checkbox"/> Other reason (Please explain below)</p> <p><input type="checkbox"/> My dependent(s)</p> <p>Explain: _____</p>
<p>If you are waiving medical coverage for yourself or your dependents (including your spouse) because of other group coverage, you or your dependents may in the future be able to enroll in this plan, provided that you request enrollment within thirty-one (31) days after your other group coverage ends. In addition, you may be able to enroll yourself and your dependents, provided that you request enrollment within thirty-one (31) days after a marriage, birth, adoption or placement for adoption. If you are waiving medical coverage for any other reason, or if you fail to complete this form, you may be limited to enrolling only during a specified enrollment period.</p>	

3. Employee / Subscriber Information					
Legal Last Name		Legal First Name			Legal M.I.
Street Address		City		State	Zip      County
Home Phone ( ) ( )	Work Phone ( ) ( )		ext.	E-mail Address	
Birthdate		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number		
Date of Hire		Hours worked per week	Position <input type="checkbox"/> Hourly <input type="checkbox"/> Salaried	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single	
Primary Care Provider Name			Employee ID		

4. Member Information and Physician Selection							
	Legal Last Name	Legal First Name	Legal M.I.	Birthdate	Gender M/F	Social Security #	Primary Care Provider Name
Spouse							
Dependent							
Dependent							
Dependent							
Dependent							
Dependent							

Do all the people reside at the address indicated above? If not, please list name(s) and address(es) below.

**5. Other Health Insurance Information (For Coordination of Benefits)**

On the day this coverage begins, will you, or any family member you are enrolling, be covered by any other health insurance including Medicare, Medicaid and continuation of coverage, such as COBRA, besides your current plan?     NO     YES  
(If yes, answer all questions below and attach a copy of your card. Use extra paper if more than one additional policy will be in force.)

Coverage type: <input type="checkbox"/> Medical Insurance	Insurance Company Name and (Area Code) Phone Number (    )	Effective Date of this coverage
Name of Insured	Insured's Employer Name	Policy Number
Family Members Covered 1.	2.	3.

**6. Agreement**

I request coverage under the Group Contract issued by Community Health Plan. I authorize my Employer to deduct from my earnings any required contributions. I understand services will be available subject to the exclusions, limitations, and benefits described in the Certificate(s).

The Group Contract, which may be issued by Community Health Plan, will not include coverage for contraceptives. I understand that I may purchase this coverage by contacting the Community Health Plan Customer Service department at (816) 271-1247 or 1-800-990-9247.

The statements and answers in this enrollment application are complete and true. I understand that the statements and answers provided by me in this enrollment application shall be the basis of any coverage issued and that this application will be attached to and incorporated into any policy that may be issued hereunder by Community Health Plan. I understand that any misstatement on this enrollment application may result in a denial of a claim and/or discontinuation of coverage. I understand that if at any time it is determined a person listed on this application did not meet the Policy's definition of dependent, or I misrepresented any of the information contained herein; Community Health Plan has the right to cancel or rescind coverage for that person or for all persons under the application, and to recover any benefits payments for such ineligible person or persons. I further understand that in the absence of fraud, the statements that I have made herein are considered representations and not warranties and that no statement voids the coverage or reduces the benefits after my coverage has been in effect for two (2) years from the Group Contract's effective date.

I authorize health care providers, insurers, health plans, claim administrators and employers to provide to Community Health Plan, or its representatives, any requested information available about my, and/or my dependents' employment and/or medical history, condition and treatment. This authorization also specifically applies to information relating to psychiatric histories and treatment, or HIV status. I authorize Community Health Plan to share such information as reasonably necessary with its representatives, provider organizations, or any other health plan or claims administrators. Such information may only be used for the following purposes: determining eligibility for coverage and benefits; administering coverage and claims for benefits; utilization review and case management; provider peer review; coordination of care; quality improvement; quality assessment and measurement, including surveys of members; accreditation; billing; or resolution of appeals and/or grievances. I authorize Community Health Plan to share such information with any provider for treatment purposes and to any such person who has an authorization to obtain such information, as may be permitted or required by law. I understand my medical records will be maintained with strict confidentiality by Community Health Plan in accordance with applicable federal and state laws.

\_\_\_\_\_  
Employee Signature

Date: \_\_\_\_\_