



**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> <input type="checkbox"/> Community Gold <input type="checkbox"/> Community Choice <input type="checkbox"/> POS-2 <input type="checkbox"/> Other _____ <p><b>PPO</b></p> <input type="checkbox"/> Select Choice <input type="checkbox"/> Quality Choice <input type="checkbox"/> HSA-Eligible High Deductible Health Plan (HDHP)	<p>(Must complete to waive medical coverage)</p> <p>I decline to enroll coverage for:</p> <input type="checkbox"/> Myself <input type="checkbox"/> Existence of other group health coverage <input type="checkbox"/> My spouse <input type="checkbox"/> Other reason (Please explain below) <input type="checkbox"/> My dependent(s) <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			Exact Height		Exact Weight

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	Exact Height	Exact Weight
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)		
<p>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 or continuation of coverage, such as COBRA, besides your current plan?    <input type="checkbox"/> NO    <input type="checkbox"/> YES          (If yes, answer all questions below and attached a copy of your card. Use extra paper if more than one additional policy will be in force.)</p>		
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. Health Statements – All Questions must be answered before application is processed**

Yes	No	Please check box if you or any person applying for coverage have had, are receiving or have received medical services from a physician or other healing arts practitioner for any of the conditions listed below. If "Yes" box is checked, please circle applicable condition and explain completely in the space provided below.
		1. Are you or any dependents to be covered currently disabled, handicapped, pregnant or scheduled for surgery?
		2. During the past 24 months, have you or any dependent to be covered been hospitalized, had surgery or incurred over \$5,000 of medical expenses or received Worker's Compensation Benefits?
		3. During the past 24 months, have you or any dependent to be covered been positively diagnosed or treated for Cancer, Tumor, Heart Disease, Stroke, Multiple Sclerosis, High Blood Pressure, Diabetes, Epilepsy, Palsy, Alcohol, Drug Abuse, AIDS or ARC? What was your last Blood Pressure? _____
		4. During the past 24 months, have you or any dependent to be covered taken medication for any mental, psychological or nervous disorder or been confined to any type of hospital (other than for an accident or pregnancy)?
		5. Are you or any dependent to be covered currently taking any medication(s)?
		6. Within the last five years, have you or any dependent been positively diagnosed and treated for any type of medical services from any type of healing arts practitioner including but not limited to a physician, nurse, medical clinic, dentist, chiropractor or mental health professional for any reason not already covered in this section?
		7. Are you or any dependent to be covered a tobacco user?

**Supplementary Health Information:** For each person to be enrolled, fill out this information for each question answered YES above. Attach additional paper if necessary.

Question #	Person's Name	Condition	Treatment	Current Status	Date of Treatment

**Describe:**

Any work or activity restrictions, limitations or related conditions

Name, address, phone number of Doctor/Provider and visit dates

If hospitalized, number of days and hospital name

List other prescription drugs here

**7. 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 include coverage for contraceptives. I understand that I may contact Community Health Plan's Customer Service department at (816) 271-1247 or 1-800-990-9247, if I wish to exclude such coverage based on my moral, ethical or religious beliefs.

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: \_\_\_\_\_