Enrollment / Change Application

Employee: Please return to your Benefits Department. Retain a copy as your temporary ID card until your permanent card is received.
Employer: Please return completed enrollment application to: ADVANTAGE/Eligibility, PO Box 80069, Indpls, IN 46280 or fax to (317) 536-3827.

ADVANTAGE
...rising above the service you expect™

Employer Use Only: ADVANTAGE cannot process this application without Authorized Personnel signature.

Signature of authorized personnel: _____ Date Signed: _____/_____/_____ Date of Hire: _____/_____/_____

Group #: _____ Effective date of coverage: _____/_____/_____ Effective date of term: _____/_____/_____

Date received by ADVANTAGE: _____/_____/_____	Entered by: _____	☐ HMO ☐ POS ☐ HDHP ☐ Choice (Sagamore Network) ☐ Other _____

SECTION 1 EMPLOYEE INFORMATION

Employer Name		Employee Email Address:	
		Do we have permission to contact you via email? ☐ Yes ☐ No	
Employee Name	Home Phone	Work Phone	1st Language Spoken: _____ 2nd Language Spoken:_____
Employee Address	City/State	Zip / County	Employment Status: ☐ Active ☐ Retired ☐ Active on Medicare ☐ Retired on Medicare

Check box that applies: ☐ **NEW ENROLLMENT** ☐ **COBRA ELECTION** ☐ **CHANGE(S) TO EXISTING ENROLLMENT** (check box(es) below that apply)
☐ Name Change ☐ Address Change ☐ Change Phone ☐ Change PCP (Complete Section 5 for those changing PCP)

☐ Add new member (Complete Section 5)
Check Qualifying Event for adding Member ☐ Principal support of ☐ Marriage to ☐ Birth of ☐ Adoption ☐ Stepchild

☐ Term Entire Family ☐ Term Dependent(s) - List names _____
Check Qualifying Event for Term: ☐ Divorce ☐ Death ☐ Rec'd other coverage ☐ Marriage of minor/dependent ☐ Ineligible due to age
☐ No longer resides with employee ☐ No longer full time student ☐ Termed employment /Retirement
☐ Other _____

SECTION 2 MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

SECTION 3 TYPE OF MEDICAL COVERAGE REQUESTED: ☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Family

SECTION 4 WAIVER OF COVERAGE

I refuse coverage under the group benefit plan of my employer. I understand that if I want to apply for this coverage at a later date, I may have to wait until the next Open Enrollment unless I have had a status change, which will permit me to enroll in The Plan. In order to enroll at a later date, I must apply for coverage within 31 days after the change of status has occurred. In the event that I refuse medical coverage, federal law requires certain disclosures. I understand the conditions of coverage and refuse to participate because:
☐ Another group plan is available and covers: ☐ ME ☐ MY SPOUSE ☐ MY DEPENDENT CHILDREN
☐ I am covered by Medicare, Medicaid, or any other federal, state provincial or other government plan. ☐ Other: _____

Signature of Waiver Applicant: _____ **Date Signed: _____/_____/_____**

SECTION 5 ENROLLMENT INFORMATION & PRIMARY CARE PHYSICIAN (PCP) SELECTION

Relationship	Name *(First, Middle, Last Name)*	Full Time Student (FTS)/Totally Disabled?	Birthdate	Sex	Social Security No.	PCP Name *(Must be within 30 air miles of your residence or workplace)*	PCP ID from AHS Provider Directory (ex: PRO1234)	Current PCP?
Employee				☐ M ☐ F				☐ Y ☐ N
Spouse				☐ M ☐ F				☐ Y ☐ N
Child 1		☐ Disabled ☐ FTS ☐ Neither		☐ M ☐ F				☐ Y ☐ N
Child 2		☐ Disabled ☐ FTS ☐ Neither		☐ M ☐ F				☐ Y ☐ N
Child 3		☐ Disabled ☐ FTS ☐ Neither		☐ M ☐ F				☐ Y ☐ N
Child 4		☐ Disabled ☐ FTS ☐ Neither		☐ M ☐ F				☐ Y ☐ N

SECTION 6 COORDINATION OF BENEFITS – Are you or any of your dependents covered by other group health insurance? ☐ Yes ☐ No

Determines which plan pays first when member or dependents have more than one group insurance coverage or Medicaid/Medicare.
Name of subscriber for other plan _____ Date of birth of subscriber for other plan _____/_____/_____
Is this court-ordered? ☐ Yes ☐ No

Name of person covered by other plan	Policy No.	Effective Date	Name of Ins. Company	Address of Ins. Company	Phone No. of Ins. Company

SECTION 7 STATEMENT OF ACKNOWLEDGEMENT

I acknowledge that I have read both Sections 8 AND 9 ON THE BACK OF THIS FORM, AND THEREBY AGREE WITH THE TERMS, CONDITIONS AND AUTHORIZATION OF Section 8 and consent to the use and disclosure of my personal health information as stated in Section 9.

Signature of Applicant: _____ **Date Signed: _____/_____/_____**

White copy: ADVANTAGE Health Solutions Yellow copy: Employer Pink copy: Employee Updated: 5/4/07

Section 8 TERMS, CONDITIONS AND AUTHORIZATIONS

I understand and agree that no benefits shall take effect until this application is approved by The Plan. I understand that I will be responsible for all charges and for any service outside my coverage effective date. I understand that I must meet all of the eligibility requirements of the Group Policy before coverage becomes effective for myself and my dependents, if any. I also understand that I am responsible for reporting to my employer promptly any change in my marital status, in the number of my eligible dependents or any change in my residence. I agree that any benefits payable on my behalf under my employer's health benefit plan may be paid directly to the provider of care. I hereby authorize any hospital, physician, surgeon, or pharmacist to release any information requested by The Plan or its representative with respect to the claim or delivery of medical care on behalf of myself or a covered dependent. A photocopy of this authorization will serve the same as an original. I authorize my employer to make the necessary deductions from my pay or from any disability or retirement annuity benefits to which I may be entitled under any group plan sponsored by my employer while I am enrolled in The Plan or until this authorization is revoked by me in writing. The information on this form is true to the best of my knowledge. I understand that all benefits for myself and my eligible dependents will be provided in accordance with the Group Policy. I agree to abide by the terms and conditions here and in the Group Policy governing membership and receipt of health services in the plan in which I have enrolled.

Section 9 USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

By signing this form and enrolling in this plan, I understand ADVANTAGE Health Solutions, Inc. [SM] has the right to utilize my personal medical information for future, known or routine needs for the purposes of treatment, payment and health care operations. This may include: coordination of care; case management; disease management; quality assessment and measurement; accreditation; decisions about the payment of services; and, other normal business operations related to administering the health plan. Information may be transmitted to or from ADVANTAGE Health Solutions, Inc. [SM] for the purpose of arranging for my health care and benefits. **I understand this consent is a condition of my enrollment in ADVANTAGE Health Solutions, Inc. [SM] and I have the right to revoke this consent in writing at any time.** I also understand I have the right to file a grievance if I feel there is a violation regarding use or disclosure of my personal health information.

Should you have any questions, please call Member Services at (800) 553-8933.

We look forward to serving you.

For more information about ADVANTAGE Health Solutions, Inc. [SM], you can log on to our website.
www.advantageplan.com