

UHY ADVISORS - INSURANCE DESIGN ADMINISTRATORS ENROLLMENT APPLICATION

Employer Use Only	
Group Name	
Group ID	Employee Code
Effective Date Requested / /	
Network	Division
Employer's Signature & Date	

SECTION 1 Your Last Name _____ First _____ M.I. _____ Address _____ City _____ State _____ Zip Code _____	Your SS No. _____ <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced In case of change due to Marriage: In case of change due to Divorce: Date of Marriage ____ / ____ / ____ Date of Divorce ____ / ____ / ____ Phone No. (____) _____ (____) _____ Employment Status: Active: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Retired <input type="checkbox"/> COBRA Date of Employment: ____ / ____ / ____ Date of Retirement: ____ / ____ / ____
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SECTION 2 <input type="checkbox"/> New Enrollment/Reinstatement (complete Section 4) <input type="checkbox"/> Change Coverage to: (check new coverage) <input type="checkbox"/> Cancel Coverage: (check those that apply) <input type="checkbox"/> Add or Delete Dependent: (complete Section 4) <input type="checkbox"/> Change Enrollee's Information: (complete Section 1 with new information) REASON: _____	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 20%;">Type</th> <th style="width: 80%;">Option</th> </tr> <tr><td>Medical</td><td></td></tr> <tr><td>PPO</td><td></td></tr> <tr><td>POS</td><td></td></tr> <tr><td>EPO</td><td></td></tr> <tr><td>Dental</td><td></td></tr> <tr><td>Vision</td><td></td></tr> <tr><td>Rx</td><td></td></tr> <tr><td>Life</td><td></td></tr> <tr><td colspan="2">Date of change: ____ / ____ / ____</td></tr> </table>	Type	Option	Medical		PPO		POS		EPO		Dental		Vision		Rx		Life		Date of change: ____ / ____ / ____	
Type	Option																				
Medical																					
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SECTION 3	OTHER COVERAGE? (Inaccurate information may result in claim delay or denial.) Is there coverage under any other group health plan available to you or any member of your family? <input type="checkbox"/> No <input type="checkbox"/> Yes, Effective Date ____ / ____ / ____ Type: <input type="checkbox"/> Active <input type="checkbox"/> Retiree <input type="checkbox"/> COBRA If Yes; Policyholder Name & ID/SS No. _____	Relationship <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child Birthdate ____ / ____ / ____ Policy # _____
	Insurance Co. Name & Address _____ _____	
	Plan Type: <input type="checkbox"/> Single <input type="checkbox"/> Husband/Wife or Parent/Child <input type="checkbox"/> Parent/Children or Family Coverage Type: <input type="checkbox"/> Medical <input type="checkbox"/> Drug <input type="checkbox"/> Dental <input type="checkbox"/> Vision	

LIST APPLICANT AND ALL ELIGIBLE DEPENDENTS								Copy of medical card required		
SECTION 4	ADD	DELETE	RELATIONSHIP	DEPENDENT NAME			Birth Date (mo/day/yr)	Full-time Student	SSNo.	Enrolled under Medicare A & B Effective Date
				Last	First	M.I.				
	<input type="checkbox"/>	<input type="checkbox"/>	Self <input type="checkbox"/> M <input type="checkbox"/> F				/ /		- -	/ /
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Husband <input type="checkbox"/> Wife				/ /		- -	/ /
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	- -	/ /
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	- -	/ /
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	- -	/ /

SECTION 5 Do your dependents reside in your home? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, give address: _____ Are any of the above Dependents disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No List Name(s): _____	Full-time students exceeding initial limiting age: (Must provide each semester to show Full-time student status) List Names _____ School Name and Address _____ Expected Graduation _____
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SECTION 6	The Beneficiary selection applies to Life/Life with AD&D Insurance available through your Employer, if any. Selection(s) of Beneficiary(ies) is(are) not valid unless signed, dated and delivered to the Employer during your lifetime.				
	Primary - Full Name	Address	SS#	Relationship	% of Benefit
	Secondary - Full Name				

Applicant's Signature _____	Date ____ / ____ / ____
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For ALL coverage enrollments a Certificate of Creditable Coverage MUST be provided.