

UHY ADVISORS - INSURANCE DESIGN ADMINISTRATORS ENROLLMENT APPLICATION

SECTION 1

Your Last Name _____ First _____ M.I. _____ Your SS No. _____
 Single Married Divorced
 Address _____ In case of change due to Marriage: _____ In case of change due to Divorce: _____
 Date of Marriage ____/____/____ Date of Divorce ____/____/____
 Phone No. (____) _____ (____) _____
 City _____ State _____ Zip Code _____
 Employment Status: Active: Full-time Part-time Retired COBRA
 Date of Employment: ____/____/____ Date of Retirement: ____/____/____

Employer Use Only

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

SECTION 2

	Type	Option	Single	Husband/Wife or Parent/Child	Parent/Children or Family	Complement to Medicare
<input type="checkbox"/> New Enrollment/Reinstatement (complete Section 4)	Medical	Plan A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Change Coverage to: (check new coverage)	Medical	Plan C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cancel Coverage: (check those that apply)	Medical	Plan D	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Add or Delete Dependent: (complete Section 4)	Medical	Plan E	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Change Enrollee's Information: (complete Section 1 with new information)	Medical	Plan F	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
REASON: _____	Dental	\$750 - D	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Dental	\$1,250 - D/003	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Rx Copay		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date of change: ____/____/____						

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?
 No Yes, Effective Date ____/____/____

If Yes; Policyholder Name & ID/SS No. _____ Relationship _____
 Self Spouse Child
 Birthdate ____/____/____
 Insurance Co. Name & Address _____ Policy # _____

Plan Type: Single Husband/Wife or Parent/Child Parent/Children or Family
 Coverage Type: Medical Drug Dental Vision

LIST APPLICANT AND ALL ELIGIBLE DEPENDENTS Copy of medical card required

ADD	DELETE	RELATIONSHIP	DEPENDENT NAME			Birth Date (mo/day/yr)	Full-time Student	ID/SS No.	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 4

Do your dependents reside in your home?
 Yes No If No, give address: _____

Do you have a disabled dependent beyond initial limiting age?
 Yes No List Name(s): _____

Enrolled under Medicare? Yes No

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 _____

SECTION 5

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				

SECTION 6

Applicant's Signature _____ Date ____/____/____

For ALL coverage enrollments a Certificate of Creditable Coverage MUST be provided.

UHY ADVISORS - INSURANCE DESIGN ADMINISTRATORS ENROLLMENT APPLICATION

SECTION 1	Your Last Name _____ First _____ M.I. _____	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. (____) _____ (____) _____
	Address _____	Employment Status: Active: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Retired <input type="checkbox"/> COBRA
	City _____ State _____ Zip Code _____	Date of Employment: ____ / ____ / ____ Date of Retirement: ____ / ____ / ____

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

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: _____	Type	Option	Single	Husband/Wife or Parent/Child	Parent/Children or Family	Complement to Medicare
	Medical	Plan G	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Medical	Plan H	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Medical	Plan I	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Medical	Plan J	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Dental	\$750 – D	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Dental	\$1,250 – D/003	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Rx Copay		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Date of change: ____ / ____ / ____							

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 ____ / ____ / ____	
	If Yes; Policyholder Name & ID/SS No. _____	Relationship <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child
	Insurance Co. Name & Address _____	Birthdate ____ / ____ / ____
		Policy # _____
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	Full-time Student	ID/SS No.	Enrolled under Medicare A & B	
				Last	First	M.I.	(mo/day/yr)			Effective Date	
	<input type="checkbox"/>	<input type="checkbox"/>	Self <input type="checkbox"/> M <input type="checkbox"/> F				/ /		- -	/ /	
	<input type="checkbox"/>	<input type="checkbox"/>	Husband Wife				/ /		- -	/ /	
	<input type="checkbox"/>	<input type="checkbox"/>	Son Daughter				/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	- -	/ /	
	<input type="checkbox"/>	<input type="checkbox"/>	Son Daughter				/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	- -	/ /	
	<input type="checkbox"/>	<input type="checkbox"/>	Son 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: _____	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 _____
	Do you have a disabled dependent beyond initial limiting age? <input type="checkbox"/> Yes <input type="checkbox"/> No List Name(s): _____	
Enrolled under Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No		

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 _____	Address _____	SS# _____	Relationship _____	% of Benefit _____

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