

<div><input type="checkbox"/> _____</div> <div><input type="checkbox"/> _____</div> <div><input type="checkbox"/> _____</div> <div><input type="checkbox"/> _____</div>		<div><input type="checkbox"/> _____</div> <div><input type="checkbox"/> _____</div>	
<div>LAST NAME: _____</div> <div>FIRST NAME: _____</div> <div>MIDDLE INITIAL: _____</div> <div>SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE</div>		<div><u>HIPAA</u> <u>CERTIFICATE</u></div>	<div><input type="checkbox"/> ATTACHED <input type="checkbox"/> PENDING</div> <div><input type="checkbox"/> NO PRIOR COVERAGE</div>
		<div><u>MARITAL</u> <u>STATUS</u></div>	<div><input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED</div> <div><input type="checkbox"/> DIVORCED <input type="checkbox"/> LEGALLY SEPARATED</div>
<div>SOCIAL SECURITY #: _____ - _____ - _____</div> <div>DATE OF BIRTH: ____/____/____</div> <div>SPOUSES DATE OF BIRTH: ____/____/____</div> <div>DATE OF HIRE: ____/____/____</div> <div>EFFECTIVE DATE: ____/____/____</div>		<div><input type="checkbox"/> ACTIVE (FULL-TIME) <input type="checkbox"/> ACTIVE (PART-TIME)</div> <div><input type="checkbox"/> RETIRED <u>WITHOUT</u> MEDICARE</div> <div><input type="checkbox"/> RETIRED <u>WITH</u> MEDICARE</div> <div> "PART A" EFFECTIVE DATE: ____/____/____</div> <div> "PART B" EFFECTIVE DATE: ____/____/____</div> <div> "PART D" EFFECTIVE DATE: ____/____/____</div> <div><input type="checkbox"/> COBRA</div>	
<div>ADDRESS:</div> <div>_____</div> <div> STREET</div> <div>_____</div> <div> CITY, STATE, ZIP</div> <div>_____</div> <div> COUNTY</div> <div>(_____) _____ - _____ (_____) _____ - _____</div> <div> HOME PHONE BUSINESS PHONE</div>		<div>MEDICAL COVERAGE*</div> <div><input type="checkbox"/> EMPLOYEE <u>ONLY</u> <input type="checkbox"/> EMPLOYEE & FAMILY</div> <div><input type="checkbox"/> NO COVERAGE*</div> <div>*IF YOU ARE SINGLE AND DO NOT WISH COVERAGE,</div> <div>OR</div> <div>IF YOU HAVE AN ELIGIBLE SPOUSE AND/OR DEPENDENTS, BUT DO NOT WISH TO COVER THEM,</div> <div>PLEASE COMPLETE A WAIVER OF PARTICIPATION FORM.</div>	

Continued on the Next Page

SPOUSE INFORMATION (MUST BE COMPLETED)

LAST NAME, FIRST NAME, MI SEX DATE OF BIRTH SOCIAL SECURITY NUMBER

SPOUSE'S COVERAGE:

MEDICARE ELIGIBLE? ☐ YES ☐ NO IS SPOUSE EMPLOYED? ☐ YES ☐ NO
"PART A" EFFECTIVE DATE: ____/____/____ ENROLLED IN GROUP HEALTH PLAN? ☐ YES ☐ NO
"PART B" EFFECTIVE DATE: ____/____/____ TYPE OF COVERAGE: ☐ SINGLE ☐ FAMILY
"PART D" EFFECTIVE DATE: ____/____/____ ☐ MEDICAL ☐ DENTAL ☐ VISION ☐ PRESCRIPTION

SPOUSE'S EMPLOYER:

NAME

STREET ADDRESS (_____) _____ - _____
PHONE

CITY, STATE, ZIP

OTHER HEALTH COVERAGE:

NAME POLICY NUMBER

STREET ADDRESS (_____) _____ - _____
PHONE

CITY, STATE, ZIP

CHILD(REN) INFORMATION

CHILD(REN)

Last Name, First Name, MI	Sex	Date of Birth	Social Security Number	Disabled		RESIDES w/Employee	
				Y	N	Y	N
_____	_____	____/____/____	____-____-____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	____/____/____	____-____-____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	____/____/____	____-____-____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	____/____/____	____-____-____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I authorize payment of benefits to any doctor, physician or other provider for service that he/she may render to me or my family. I certify that all the above information is correct to the best of my knowledge. I desire to participate in the group medical program.

Under federal law it is a crime to knowingly and willfully make a false statement in connection with the delivery or payment for health care benefits or services (18 USC SEC. 1035). It is also a federal crime to attempt to defraud a health program or to knowingly and willfully steal or otherwise convert money from a health care fund (18 USC SEC. 669 and 18 USC SEC. 1347). These crimes are punishable by a fine or imprisonment or both.

SIGNATURE

DATE