



MEDICAL & DENTAL ENROLLMENT FORM SMALL EMPLOYER GROUP

For PHP use Only

THIS SECTION TO BE COMPLETED BY EMPLOYER

Employer Name _____ Benefit Plan #: _____ Employee Division _____

Effective Date _____ Date of Employment _____ # of Hours Worked Weekly _____

Status: Full Time Part Time Retiree

Date of Return from Layoff _____ Date of Part-Time to Full-Time _____

Date of Return from Leave of Absence _____ Date of Qualifying Event _____

(Please attach documentation such as court documents, Certificate of Creditable Coverage, etc.)

COBRA ONLY:

Last Day Worked _____

FMLA End Date _____

THIS SECTION TO BE COMPLETED BY EMPLOYEE

SS # (Required)	Last Name	First Name	Middle Initial
Address		City	State
Home Phone		Work Phone	Date of Birth
			<input type="checkbox"/> Male <input type="checkbox"/> Female

Application for HEALTH Coverage (check one): Employee only Employee & Spouse Employee & Children Family

Application for DENTAL Coverage (check one): Employee only Employee & Spouse Employee & Children Family

EMPLOYEE/DEPENDENT DATA List all Dependents eligible for Coverage. A Dependent is a person who is: 1) the Subscriber's legal spouse; 2) a child who is a United States citizen or legal resident of the United States and a) a son or daughter of the Subscriber regardless of support level, or b) a step-child, child subject to legal guardianship, grandchild or other blood relative who depends on the Subscriber for more than 50% of total support; 3) any child of the Subscriber who is recognized under a QMCSO as having a right to enroll under the Contract. List last name if different from employee.

Relationship	Dependents Name (Last Name, First Name, M.I., and address if different)	Medical Coverage	Dental Coverage	Marital Status	Gender	Social Security # <small>(required for Federal reporting)</small>	Birth Date Mo./Day/Yr.	Height	Weight
Employee		Y N	Y N	S M	M F				
Spouse		Y N	Y N	S M	M F				
		Y N	Y N		M F				
		Y N	Y N		M F				
		Y N	Y N		M F				
		Y N	Y N		M F				
		Y N	Y N		M F				

COORDINATION OF BENEFITS INFORMATION:

HAVE YOU EVER BEEN A POLICYHOLDER OF PHP BEFORE? Y N

On the date that Coverage is to be effective, will you or your Dependent(s) have any other Coverage? Y N If yes, complete the following:

Health Plan Name _____ Policy/Group/ID Number _____

Dental Plan Name _____ Policy/Group/ID Number _____

Claims Address/Phone Number _____ Effective Date _____ Termination Date _____

Policyholder's Name _____ Policyholder's Social Security Number _____

Covered Individuals _____ Policyholder's Birth Date _____

Employer through which coverage is held _____ Medicare Plan A (Hospital only) A & B (Hospital & Medical)

PLEASE COMPLETE REVERSE SIDE

THIS SECTION MUST BE COMPLETED

- 1. Has any person eligible for coverage been treated during the past 5 years for: (Explain any yes answers below.)**
- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| A. Diabetes or sugar, albumin or blood in the urine?
If yes, when first diagnosed? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Chest pain, heart murmur, shortness of breath, angina or other heart, circulatory disorder or high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Stroke, epilepsy, fainting, dizziness, headaches or any disorder of the brain or nervous system? | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Tuberculosis, asthma, hay fever, lung or respiratory disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Stomach or duodenal ulcer, other ulcer, colitis; disorder of gall bladder, liver, stomach or intestines? | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Varicose veins, varicose ulcers, phlebitis or hernia of any kind? | <input type="checkbox"/> | <input type="checkbox"/> |
| G. Kidney, bladder or prostate disorder or other urinary disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| H. Tumor or disease of the breast, reproductive organs or abnormal menstrual period? | <input type="checkbox"/> | <input type="checkbox"/> |
| I. Arthritis, rheumatism or any disorder of the joints, muscles, back or bones? | <input type="checkbox"/> | <input type="checkbox"/> |
| J. Cancer, tumor or ulcer of any kind, growth, cyst, or syphilis? | <input type="checkbox"/> | <input type="checkbox"/> |
| K. Any disorder of eyes, ears, nose or throat? | <input type="checkbox"/> | <input type="checkbox"/> |
| L. Alcoholism, narcotic addiction or joined any organization for alcoholism or drug abuse? | <input type="checkbox"/> | <input type="checkbox"/> |
| M. Nervous or mental disorder treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| N. Diseases of the immunity system, including AIDS or ARC? | <input type="checkbox"/> | <input type="checkbox"/> |

- 2. Has any person eligible for coverage: (Explain any yes answers below.)**
- | | | |
|--|--------------------------|--------------------------|
| | Yes | No |
| A. Been released from the military for medical reasons? | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Had any life or health insurance declined, postponed or modified, or had a waiver or extra premium added? | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Received payment for disability due to illness or injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Had a change of weight of more than 10 lbs. in the last 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
- 3. Within the past 5 years, has any person eligible for coverage: (Explain any yes answers below.)**
- | | | |
|--|--------------------------|--------------------------|
| A. Had a physical exam, electrocardiogram, x-ray, blood test, diagnostic test, or seen a physician for any reason? | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Had surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Been advised to have a surgery not yet done? | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Had any medical treatment, health impairment, or birth defects not mentioned above? | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Tested positive for the AIDS virus? | <input type="checkbox"/> | <input type="checkbox"/> |
- 4. Have medications been used in the last 12 months?**
- A. If yes, please list name, dose, and condition used for:

- 5. Are any females eligible for coverage now pregnant?**
- | | | |
|---|--------------------------|--------------------------|
| A. If yes, when is birth expected? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| B. If no, date of last menstrual cycle? _____ | | |

"YES" answers to any part of questions 1, 2, 3, or 4 are to be explained below. Please give complete details.			
Question # and Name of Person	Diagnosis, treatment or reason for physical check-up	Date of treatment, length of hospital stay and degree of recovery	Doctor's name and phone number

REFUSAL OF COVERAGE

I have decided not to apply for Coverage for: **MEDICAL:** Employee Children Spouse **DENTAL:** Employee Children Spouse

Reason: _____ Employee Signature: _____ Date: _____

I (WE) HEREBY REPRESENT that all statements and answers herein are full, complete and true. These statements and answers are to be considered as the basis for Coverage under the Plan. I understand that (1) this enrollment form constitutes a part of the Plan Contract and (2) no Coverage will be effective until the date specified by the Plan.

I REALIZE THAT FALSE INFORMATION OR OMISSIONS IN THIS FORM WILL RESULT IN CANCELLATION OF COVERAGE AND MAY BE GROUNDS FOR THE PLAN TO COLLECT DAMAGES.

EMPLOYEE SIGNATURE: _____ **Date:** _____
(Signature is required even if refusing coverage)

SPOUSE SIGNATURE: _____ **Date:** _____
(Signature is required even if refusing coverage)

EMPLOYER SIGNATURE: _____ **Date:** _____

IF YOU PREFER TO RETURN THIS FORM CONFIDENTIALLY, PLEASE PLACE IN A SEALED ENVELOPE.

Physicians Health Plan of Northern Indiana, Inc.

PHP Insurance Company of Indiana, Inc.

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