



MEDICAL & DENTAL ENROLLMENT FORM

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	Zip
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

DEPENDENT DATA If you wish to Cover your Dependents, complete the following information for each Dependent to be Covered. 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 Dependents oldest to youngest. List last name if different from employee.

Relationship	Dependents Name (Last Name, First Name, M.I., and address if different)	Medical Coverage	Dental Coverage	Social Security Number (required for Federal reporting)	Birth Date Mo./Day/Yr.	Gender (Circle)
Spouse		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)

REFUSAL OF COVERAGE

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

Reason: _____ Employee Signature: _____ Date: _____

Reason: _____ Spouse 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.

EMPLOYEE SIGNATURE: _____ **EMPLOYER SIGNATURE:** _____
Date: _____ Date: _____

Physicians Health Plan of Northern Indiana, Inc.

PHP Insurance Company of Indiana, Inc.

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