



ENROLLMENT/ CHANGE FORM

Hometown Health Use Only

G#																				
M#																				
L																				
F,M																				

HUMAN RESOURCES USE ONLY

EMPLOYER _____ GROUP # _____ EFFECTIVE DATE _____

EMPLOYEE'S WEEKLY HOURS _____ EMPLOYEE'S DATE OF HIRE _____ EMPLOYER SIGNATURE _____

EMPLOYEE INFORMATION

NAME (LAST)		(FIRST)		(MI)	SOCIAL SECURITY NUMBER			
MAILING ADDRESS (STREET OR PO BOX)				CITY	STATE	ZIP CODE	COUNTY	
PHYSICAL ADDRESS				CITY	STATE	ZIP CODE	COUNTY	
DATE OF BIRTH MO/DAY/YR	MARITAL STATUS MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/>		OCCUPATION	HOME PHONE ()		WORK PHONE ()		

PLAN ELECTED

HMO PPO
 Dental HMO TPA
 Dental PPO
 PPO w/HSA*

Complete the following for Coordination of Benefits (COB)
 Do you or any of your Dependents listed below have Medical/Health Insurance (Including Medicare/Medicaid)?
 Yes No

**Street address only, no PO boxes. If yes, please provide copy of insurance card (front & back).*

CONTRACT TERMINATION ONLY

COMPLETION OF THIS SECTION WILL TERMINATE COVERAGE FOR SUBSCRIBER AND ALL DEPENDENTS

LEFT COMPANY MOVED DISSATISFIED
 DECEASED INELIGIBLE OTHER _____

REASON FOR MEMBER'S AND/OR DEPENDENT'S CHANGES

New Hire Name Annual Election Child (check below)
 Rehire Address Surviving Dependent ___ Foster
 PT/FT Reinstatement Waive Coverage ___ Adopted
 Transfer COBRA (18-29-36) ___ Grandchild
 Retiree Other _____ ___ Court Ordered
 Plan Change: From _____ To _____ ___ Disabled

ADD / DELETE DEPENDENT

MARRIAGE DIVORCE
 BIRTH/ADOPTION LOSS OF DEPENDENT STATUS
 LOSS OF INSURANCE DECEASED
 (Attach legal documentation as proof of above event)

MEMBER INFORMATION - COMPLETE WITH NEW OR CHANGE INFORMATION

ACTION	* (LAST)	(FIRST)	(MI)	SOCIAL SECURITY NUMBER	COVERAGE			BIRTHDAY MO.DAY.YR.	SEX M/F	CHECK IF ** STUDENT OVER 19	RESIDE W/ EMP.? YES/NO	PRIMARY CARE PHYSICIAN*** (if required)
					MEDICAL	DENTAL	VISION					
ADD <input type="checkbox"/>	EMPLOYEE											
CHANGE <input type="checkbox"/>	THIS SHADED SPACE FOR HOMETOWN HEALTH USE ONLY											
DELETE <input type="checkbox"/>	THIS SHADED SPACE FOR HOMETOWN HEALTH USE ONLY											
ADD <input type="checkbox"/>	Spouse (Must be legally married)											
CHANGE <input type="checkbox"/>	THIS SHADED SPACE FOR HOMETOWN HEALTH USE ONLY											
DELETE <input type="checkbox"/>	THIS SHADED SPACE FOR HOMETOWN HEALTH USE ONLY											
ADD <input type="checkbox"/>	Dependent Child (Relationship)											
CHANGE <input type="checkbox"/>	THIS SHADED SPACE FOR HOMETOWN HEALTH USE ONLY											
DELETE <input type="checkbox"/>	THIS SHADED SPACE FOR HOMETOWN HEALTH USE ONLY											
ADD <input type="checkbox"/>	Dependent Child (Relationship)											
CHANGE <input type="checkbox"/>	THIS SHADED SPACE FOR HOMETOWN HEALTH USE ONLY											
DELETE <input type="checkbox"/>	THIS SHADED SPACE FOR HOMETOWN HEALTH USE ONLY											
ADD <input type="checkbox"/>	Dependent Child (Relationship)											
CHANGE <input type="checkbox"/>	THIS SHADED SPACE FOR HOMETOWN HEALTH USE ONLY											
DELETE <input type="checkbox"/>	THIS SHADED SPACE FOR HOMETOWN HEALTH USE ONLY											

*ATTACH LEGAL DOCUMENTATION FOR DEPENDENTS WITH DIFFERENT LAST NAMES TO BE COVERED. ** PROOF MUST BE SUBMITTED
 ***IT IS MEMBER'S RESPONSIBILITY TO VERIFY PHYSICIAN AVAILABILITY IN THEIR AREA.

PREVIOUS COVERAGE: If you had previous medical coverage, please supply your HIPAA Certificate of Creditable Coverage.

ACKNOWLEDGEMENT OF TERMS Employee Signature **X** _____ Date _____

ACKNOWLEDGEMENT OF TERMS

I understand and agree that, with the exception of emergency procedures, all services must be performed either by a Hometown Health participating provider or authorized in advance and in writing to qualify for coverage by Hometown Health.

I understand that I am responsible for paying any required copayments or coinsurance or both directly to the providers of healthcare at the time of service.

I agree to be bound by all terms of the plan under which I am applying for coverage for as long as I am covered under the plan.

I certify that, to the best of my knowledge, the information shown on the front of this form is correct.

I have read and understand the terms of this application.

My signature on the front of this form constitutes acceptance of the terms listed above.

Key to plan types:

HMO Health Maintenance Organization
PPO Preferred Provider Organization
TPA Third Party Administrator for self-funded plan
HSA Health Savings Account