



# Employee Group Health Enrollment Form

Location  Job Title  Group No.:

## Section 1 – Employee Information

Employee Last Name	First Name	M.I.	Sex	Birth Date (MM/DD/YY)	Social Security Number
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Employee Home Address			Home Telephone Number		
<input type="text"/>			<input type="text"/>		
City	State	Zip Code	Work Telephone Number		Extension
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>
Hire Date	Additional Comments or Explanations				
<input type="text"/>	<input type="text"/>				

## Section 2 – Medical Plan Coverage Elections or Waiver of Coverage

### Coverage Desired

	Medical	Dental	Vision
Employee Only	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 Party	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Decline Coverage

I have decided not to apply for Health coverage at this time for myself or my dependents (if any). (Note: See Section III. ENROLLMENT AND COVERAGE in the Plan booklet for information on how you may be able to enroll in the future. Employee must sign here if declining coverage.

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## Section 3 – Spouse Information

Spouse's Last Name	First Name	M.I.	Sex	Birth Date (MM/DD/YY)	Spouse's Social Security Number
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Name of Spouse's Employer (or "Not Employed")	Spouse's Work Telephone Number		Extension	Yes <input type="checkbox"/> Is spouse covered by another health plan? If yes, you must complete the "Other Insurance" section on back.	
<input type="text"/>	<input type="text"/>		<input type="text"/>	No <input type="checkbox"/>	

## Section 4 – Dependent Children Information

Dependent's Last Name	First Name	M.I.	Sex	Relationship	Birth Date (MM/DD/YY)	Social Security Number
					/ /	- -
					/ /	- -
					/ /	- -
					/ /	- -
					/ /	- -
					/ /	- -

If enrolling dependents, you must answer this question → Yes  No  Are any of the dependent children you are enrolling covered under another health plan? If yes, you must complete "Other Insurance" section on back.

## Section 5 – Employee Signature

**Please read carefully before signing:** I certify that the information on this enrollment form is true and complete. I hereby apply for this coverage. I authorize my employer to make the necessary payroll deductions. I authorize any health care provider to release all information pertaining to care provided to me or my dependents. A photocopy of this authorization shall be valid as the original.

X    
Employee Signature Date Signed

## Section 6 - Other Insurance Information

If you, or any member of your family are covered by another health plan, you must complete this section. Please consult the other plan's ID card in order to give the following specific information we can use to coordinate your benefits with other health coverage you may have.

### Other Health Plan #1

Name of health plan

Group or policy #

Telephone number of health plan

Date coverage began

Names of all individuals covered under this health plan and any additional explanations or information about this coverage

## Section 7 - Previous Coverage Information

If you or any member of your family have had prior coverage, please attach a copy of your Certificate of Creditable Coverage detailing who the prior coverage was with, the date it began, the date it ended, and which members of your family, if any, were covered under this prior carrier. Please indicate below your prior carrier's information. If you do not submit prior coverage information, pre-existing condition limitations may apply.

Name and Number of Prior Health Carrier:

Prior Coverage Start Date

Prior Coverage End Date

Sign here if you've had no prior coverage, or if there's been a break in coverage greater than 62 days

## Section 8 - Electronic Data Information

For your security and privacy reasons as well as timeliness, we will send e-mail notices when a claim has been processed for you or your family members. This gives you the opportunity to view on our secure web-site, [www.talltreehealth.com](http://www.talltreehealth.com), all information regarding your claims and eligibility including your Explanation of Benefits (EOB). You will also be able to print your EOBs from the website. Please provide us with your e-mail address below. If you do not have access to the internet, mark the following box and a paper EOB will be mailed to you.

I would like to use the internet to access my insurance information including Explanation of Benefits. My e-mail address is:

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I understand that I will not receive Explanation of Benefits in the mail.

I do not have access to the internet and want to receive my Explanation of Benefits in the mail.

## Office Use Only

Regular Enrollment

Completed within 31 days of eligible date

Late Enrollment

NOT completed within 31 days of eligible date

Effective date of coverage:

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Employee Group Representative

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