

APPLICATION & ENROLLMENT FORM

- New Group Enrollment
 Addition of Dependent
 Late Enrollment
 Change of CMG/IPA Physician
 New Hire
 Requested effective date



Check Desired Plan

- as Offered by Employer:
 Full Network
 ChampionHEALTH
 P.O.S.

Applicant Information: Applicant must complete this section.

Last Name		First Name		M.I.	Home Phone
<input type="text"/>		<input type="text"/>		<input type="text"/>	(<input type="text"/>) <input type="text"/>
Home Address <small>Must be complete. P.O. Box not acceptable</small>				Date of Marriage	
<input type="text"/>				<input type="checkbox"/> Single <input type="checkbox"/> Married	
City		State	Zip Code	E-Mail Address	
<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	
Employer		Group # (if assigned)		Occupation	
<input type="text"/>		<input type="text"/>		<input type="text"/>	
				Date of Hire	
				Month <input type="text"/> Day <input type="text"/> Year <input type="text"/>	

Applicant/Family Information: List yourself and all eligible family members to be enrolled. If a listed family member's last name is different from yours, please explain below. Height and weight must be stated accurately.

Provider Selection: Please select a Contracting Medical Group (CMG) or a physician from an Independent Practice Association (IPA) for each family member to assure prompt processing of this application.

Last Name	First Name	M.I.	Height	Weight	Date of Birth	Social Security Number	Name of CMG or IPA Physician	CMG/IPA#	Current Doctor?
					Month Day Year				Y N
Applicant									<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> M <input type="checkbox"/> F									<input type="checkbox"/> <input type="checkbox"/>
Spouse									<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> M <input type="checkbox"/> F									<input type="checkbox"/> <input type="checkbox"/>
Dependent									<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> M <input type="checkbox"/> F									<input type="checkbox"/> <input type="checkbox"/>
Dependent									<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> M <input type="checkbox"/> F									<input type="checkbox"/> <input type="checkbox"/>
Dependent									<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> M <input type="checkbox"/> F									<input type="checkbox"/> <input type="checkbox"/>
Different last name explanation:									

If available, I would prefer to receive materials in the following language _____.

The following information is voluntary and will help us to better serve your needs. Please check the ethnicity with which you most closely identify.

- Alaskan/Native American
 Caucasian
 African American
 Hispanic
 Asian/Pacific Islander
 Other _____

Other Health Insurance

Please fill out this section if you and any of your eligible family members are currently covered by other medical insurance, or had previous health insurance.

Name of Member(s)	Previous Insurer	Policy Number	Policy Effective Date	Employer's Name
<input type="text"/>	<input type="text"/>	<input type="text"/>	Month <input type="text"/> Day <input type="text"/> Year <input type="text"/>	<input type="text"/>
Name of Member(s)	Current Insurer	Policy Number	Policy Effective Date	Employer's Name
<input type="text"/>	Name <input type="text"/>	<input type="text"/>	Month <input type="text"/> Day <input type="text"/> Year <input type="text"/>	<input type="text"/>
	Address <input type="text"/>	Are you or any member(s) of your family eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	City <input type="text"/> State <input type="text"/> Zip <input type="text"/>	Name <input type="text"/>	Name <input type="text"/>	Name <input type="text"/>




Be sure to sign and date application on back page. ▶

H Health Questionnaire Have you or any of your dependents: Ever had, consulted for, had treatment rendered, been to have treatment, or received treatment, or been hospitalized for any of the following conditions:

	Yes	No
1. Cardiovascular disease or heart attack, stroke, disorder of the kidney, stomach, intestines or liver, mental or nervous condition, alcohol or chemical abuse, central nervous system disorders, diabetes, any disorders of the lungs or respiratory system, cancer or immune deficiency disorder, AIDS, or AIDS related complex?	<input type="checkbox"/>	<input type="checkbox"/>
2. During the last five (5) years, had surgery or been confined in any hospital, sanitarium, convalescent facility or specialized care facility or had medical expenses of more than \$5,000?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does any person to be covered have any knowledge of or any signs of being pregnant? If yes, what is the expected date of delivery?	<input type="checkbox"/>	<input type="checkbox"/>
4. Currently taking any prescribed or over-the-counter medications?	<input type="checkbox"/>	<input type="checkbox"/>
5. Been unable to perform his/her usual duties or activities for more than 10 consecutive days during the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>

Please explain and provide us with FULL DETAILS for each "Yes" answer to any condition(s) checked in all the preceding boxes. Include name of family member, nature of illness, dates and duration of treatment. In addition, please give details below of last doctor visit and/or physical examination for all family members listed regardless of the date or reason.

 **Attach additional sheets if necessary.**

Condition No.	Family Member Name (Name used on doctor's record)	Name of hospital, full name of every physician or clinic (include zip code)	Name of condition(s) or illness(es) treated	Indicate treatment rendered such as checkup, x-ray, lab and surgical procedures, etc.
	Name Date Began: Mo: <input type="text"/> Yr: <input type="text"/> Still Under Treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No Date Ended: <input type="text"/>	Name Address City State Zip Phone ()		Medication Taken: Date Prescribed: <input type="text"/> Dosage:
	Name Date Began: Mo: <input type="text"/> Yr: <input type="text"/> Still Under Treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No Date Ended: <input type="text"/>	Name Address City State Zip Phone ()		Medication Taken: Date Prescribed: <input type="text"/> Dosage:
	Name Date Began: Mo: <input type="text"/> Yr: <input type="text"/> Still Under Treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No Date Ended: <input type="text"/>	Name Address City State Zip Phone ()		Medication Taken: Date Prescribed: <input type="text"/> Dosage:

I, the undersigned, represent that: All information on this application is true and complete to the best of my knowledge, and that no material information has been withheld or omitted concerning the past and present state of the applicant's or any family member's health.

I, the undersigned, understand that: I herewith give my consent to all doctors, hospitals and providers of health services to furnish any and all records pertaining to my family's or my own medical history. Universal Care may require prior medical records and that the applicant agrees to sign a Medical Records Release form.

I understand and agree that by signing this application I am waiving my constitutional right to trial by jury.

Universal Care will rely upon the application information for rejecting or contracting with the applicant, and the discovery of additional material facts, known by the applicant but not disclosed herein, may result in the rescission or modification of any contract entered into.

I hereby authorize my employer or association to deduct my paycheck any required contribution for group benefits for which I am eligible, and I shall abide by the provisions of coverage in the service agreement under which I am enrolled.

It is my responsibility to report any change in eligibility of my dependents.

Any claims asserted by myself or my dependents against Universal Care, its employees or agents, whether based in contract, tort or otherwise are subject to binding arbitration.

Subscriber Signature (Applicant)

Date

Month	Day	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

Coverage Declination

To be completed if any Universal Care coverage is declined or refused by an eligible employee and/or their eligible family members.

I. Health Plan Coverage (check if declined)
I decline coverage for:

- Myself Children Only
 Spouse Only Spouse and Children

2. Reason for Declining Health Plan Coverage (check one)

- Covered by Spouse's Group Coverage
 Spouse covered by Employer's Group Medical Coverage
 Covered by CHAMPUS or CHAMPVA
 Enrolled in another Group Plan

Carrier Name

Medicare Other (explain):

I acknowledge that the available coverages have been explained to me by my employer, and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage. **I know that if I later decide to elect coverage, and I was not covered under another employer health benefit plan during the initial enrollment period, I and/or my dependents will be considered a late Enrollee and will be subject to a 12 month waiting period from the date I later decide to elect coverage.** I may also be subject to a six-month pre-existing condition exclusion. My decision not to apply for coverage now could leave me without coverage later.

Employee Signature (Sign only if declining coverage for yourself or eligible family members.)

Date

Month	Day	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

 **For office use only**

Member # <input type="text"/>	Plan Code <input type="text"/>	Broker # <input type="text"/>	Effective Date Month <input type="text"/> Day <input type="text"/> Year <input type="text"/>	Reviewed By <input type="text"/>	Date <input type="text"/>
Group # <input type="text"/>	Agent # <input type="text"/>	Dental Center Code <input type="text"/>	Medical Center Code <input type="text"/>	Approved By <input type="text"/>	Date <input type="text"/>