PREFERRED HEALTH PLAN

EMPLOYEE - COMPLETE SECTION 1, 3, 4 & 5

EMPLOYER - COMPLETE SECTON 2

Group Enrollment Application & Change Form

REQUESTED EFFECTIVE DATE: _____

PO Box 9 • Klamath Falls OR 97601-0383 • Ph 541.882.1466 • Fax 541.882.1447 • 1.800.303.8680 • www.preferred-health-plan.com

SECTION 1 - EMPLOYEE INFORMATION

Employee Name: (Last) (First) (MI)	Home Phone: ( )	Marital Status: ☐ Single ☐ Married ☐ Divorced		
Home Address: (Street & Number)	City:	County:	State:	ZIP Code:

SECTION 2 - PURPOSE OF APPLICATION

Employer Name:	☐ New Group Enrollment ☐ Existing Group New Employee ☐ Annual Enrollment
Group Number: / Occupation Title & Division:	***IF SPECIAL ENROLLMENT, please complete the following:*** Date of Change/Event: _____ ☐ Marriage ☐ Divorce ☐ Birth
Date of Hire: / Date transferred from **P-T** to **F-T** or Date of **Eligibility:**	☐ Adoption ☐ Dependent Change ☐ Involuntary Loss of Coverage ☐ Death ☐ Return from Layoff ☐ Other: _____

SECTION 3 - CREDITABLE COVERAGE INFORMATION

If you or your eligible family dependents have existing health coverage or are enrolling within 63 days of the termination of that coverage, you may be eligible for prior coverage credit towards pre-existing or other coverage limitations. **Please complete the following questions to receive prior coverage credit.**

Other insurance company name:	Other insurance company address:	Other insurance phone number:

Names of all enrollees covered by the other insurance company:

Date other coverage began:	Date other coverage ends:

Will the other coverage remain in effect when your group coverage begins?

☐ No ☐ Yes, with the following enrollees to remain on coverage: _____

SECTION 4 - ENROLLMENT INFORMATION (attach additional sheets if necessary for complete information)

ADD	DROP	**WAIVE** - Write in name of Co. & Type of Policy	Relationship to Employee	Name (Last, First, MI)	Birthdate MM-DD-YY	Sex M - F	Social Security Number
☐	☐	☐ Other Carrier Name __Group __Individual	Self (from Part 1)				
☐	☐	☐ Other Carrier Name __Group __Individual	Spouse				
☐	☐	☐ Other Carrier Name __Group __Individual					
☐	☐	☐ Other Carrier Name __Group __Individual					
☐	☐	☐ Other Carrier Name __Group __Individual					
☐	☐	☐ Other Carrier Name __Group __Individual					

If any person listed above is eligible for Medicare, attach a copy of the Medicare Card and complete the information below:

Part A - Effective Date: _____ Part B - Effective Date: _____

Part A - Effective Date: _____ Part B - Effective Date: _____

Part A - Effective Date: _____ Part B - Effective Date: _____

Please explain the relationship of any family member listed above whose last name is different from yours:

_____

If you are adding dependent children and if you or your spouse have been divorced or legally separated, **attach a copy of the court decree** and indicate who has legal custody of your child(ren): ☐ Father ☐ Mother ☐ Other: _____ Date Awarded Custody: _____

Has the parent without custody been required by court decree to provide coverage for the dependent child(ren)? ☐ Yes ☐ No

If Yes, list other coverage provided: _____

SECTION 5 - AUTHORIZATION AND DECLARATION

I hereby verify that all the information specified above is accurate and complete, and all the persons for whom I am requesting enrollment are eligible for coverage. The changes on this form supersede all previous forms submitted. I authorize my employer to deduct from my earnings the amount, if any, for the coverage selected.

Employee Signature _____ Date: _____