

1. Tell us about you			2. New Enrollment			4. Where you work								
Last Name _____		First Name _____ M.I. _____	<input type="checkbox"/> New Hire _____ Open enrollment _____ <input type="checkbox"/> COBRA/Continuation Date Of Qualifying Event _____ Reason _____			Company Name _____			Plan Number _____		Occupation _____			
Home Address (Number and Street or P.O.Box / Apt. Number) _____			3. Enrollment Change			Are you actively at work? <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO) REASON <input type="checkbox"/> SICK <input type="checkbox"/> INJURED <input type="checkbox"/> OTHER								
City _____ State _____ Zip Code _____		Home Telephone () _____ Work Telephone () _____				Are you currently claiming Workers' Compensation Medical benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Email _____			5. Medical Pre-Existing Condition Portability and Coordination of Benefits Statement			Are you or any other eligible dependent listed on this form currently confined to a hospital or other healthcare facility, totally disabled or physically impaired? <input type="checkbox"/> YES <input type="checkbox"/> NO								
Fax () _____		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Separated <input type="checkbox"/> Widowed				Change:			Do you work 30 or more hrs. per week? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Date _____/_____/_____						<input type="checkbox"/> Address Change <input type="checkbox"/> Name Change <input type="checkbox"/> Other Change Reason _____ Date _____/_____/_____			Date of Full Time Hire _____/_____/_____ Date of Part Time Hire _____/_____/_____ Date of Rehire _____/_____/_____					
6. List Family Members to be Added/Cancelled														
	First Name	M.I.	Last Name	Add	Cancel	SS #	Date of Birth (mm/dd/yr)	Full Time Student Age 19 or Over (Circle Yes Or No Below)	If age 19 or over indicate name of recognized institution for full time students below	Prior Carrier's Name	Prior Group Wait. Period	Prior Eff. Date	Prior Term. Date	
SELF __ M __ F				___	___		___/___/___							
SPOUSE __ M __ F				___	___		___/___/___							
DEPENDENTS: Children over 19 may be eligible if disabled, or unmarried full-time students _____ Check if any dependents are disabled														
DEPENDENT __ M __ F				___	___		___/___/___	Y N						
DEPENDENT __ M __ F				___	___		___/___/___	Y N						
DEPENDENT __ M __ F				___	___		___/___/___	Y N						
7. Medicare/Medicaid Do you or any covered dependent have Medicare/Medicaid coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO Have you or any covered dependent applied for Medicare/Medicaid disability? <input type="checkbox"/> YES <input type="checkbox"/> NO														
Name (Self) _____		Are you actively at work? <input type="checkbox"/> YES <input type="checkbox"/> NO		Retirement Date _____/_____/_____		Name (Dependent) _____		Are you actively at work? <input type="checkbox"/> YES <input type="checkbox"/> NO		Retirement Date _____/_____/_____				
Medicare No. _____		Effective Dates: Medicare A (Hospital) _____ Medicare B (Medical) _____				Medicare No. _____		Effective Dates: Medicare A (Hospital) _____ Medicare B (Medical) _____						

I apply for coverage (or change in coverage) as specified above and authorize my employer to deduct any required premium contributions from my pay. I understand that all coverage and services are subject to the Exclusions, Limitations and Conditions of the Certificate of Insurance document, which is incorporated by reference herein. I understand that in the future, The PerfectHealth Insurance Company, ("PerfectHealth") may need to obtain medical information for the purpose of settling a claim. To that end, I authorize PerfectHealth or any physician, hospital, insurer or any organization or person having such records, data or information about me or my family's health or medical history or benefits, including those related to psychiatric care or drug or alcohol use, to furnish such records, data or information as may be requested by or of PerfectHealth. Such authorization shall further apply to the release of my or my family's records, data or information to contractors, agents or representatives of PerfectHealth if they agree to keep it confidential. A copy of this authorization shall be as effective as the original. I understand that false and/or incomplete responses or statements may result in rescission of coverage and/or non payment of claims for myself or my dependents. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. I certify that my statements in this form are true and complete to the best of my knowledge and belief.

8. Employee Signature	X	Date _____/_____/_____
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