KINGSTON TRUST FUND
ENROLLMENT APPLICATION FOR INFERTILITY PROGRAM

Infertility Benefits will not be available until your Enrollment has been received and approved by the Pre-certification Office.

Plan: **Kingston Trust Fund Health Plan**
Pre-certification: **Hughes and Associates Phone: (844) 583-3863 Fax: (601) 981-1778**
196 Charmant Drive Ste 3, Ridgeland, MS 39157

Member Name: ____ Social Security #: ___________________

Patient Name: ____ Social Security #: ___________________

Patient Date of Birth: ____________________________ Date Covered by this Plan: _________________

Must be covered continuously for 18 months before benefits are available.

Date Infertility Diagnosed: _____________________

Primary Physician (for infertility care): ____

Physician Address: ____

Phone: ______________________ Fax: ___________________ E-mail: _____________________________

Is Dr. Board Certified in Reproductive Endocrinology? [ ] Yes [ ] No

(list certifications): ____

Is doctor willing to Participate in Program? [ ] Yes [ ] No

Have you been previously treated for infertility? [ ] Yes [ ] No Please list dates of service and provider:

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Disclosure: Special benefits are provided to those members enrolled in this program, subject to verification they have an infertility condition. This is a special case management program with specialists who will track, monitor and coordinate your treatment program with you and your providers.

Medical Release: I hereby authorize any health care facility, physician, surgeon, counselor, therapist or insurance company to provide all information pertaining to me or any of my dependents or spouse who are covered regarding past or present medical or mental conditions, any examination or treatment, including treatment for alcohol abuse, substance abuse, mental or emotional disorders, AIDS, ARC (Aids Related Complex), HIV and to any illness, injury or condition that I/We or my dependent(s) have had at any time in the past or in the future until the expiration of this authorization and/or coverage to the following authorized personnel of the individuals and companies responsible for the administration of this plan: Kingston Trust Fund, the Claims Supervisor, any third parties contracted to provide service for this plan (pre-certification firm, PPO, case manager, agent, or prescription benefit manager, etc.), and my employer only for purposes of eligibility and verification of benefits. No information will be used for any employment related matter. I understand this information is collected in connection with the evaluation and processing of any eligibility for benefits, determining medical necessity, and underwriting as required by the Plan. This authorization is valid as long as I am covered by this Plan or until changed in writing; and a photocopy is as valid as the original. I understand this information shall be treated with utmost confidentiality and will be separately maintained from my employment information accordingly to the Plan's HIPAA Privacy Policy.

Acceptance: As a participant in this program, you agree to all the conditions as outlined in this plan for the treatment of infertility and understand that there are certain conditions and limitations. Failure to abide by the program rules and requirements will result in non-payment for those services which have not been pre-approved in advance of the treatment or in accordance with the plan rules.

Patient's Signature: ____ Date: ________________________

Spouse's Signature: ____ Date: ________________________

Call the Precertification or Compliance Office for any questions or general information on this program.
This form may be returned via fax or mail to the Pre-Certification Office listed above.