Unit Name: ___________________________________
Member Name: _______________________________

Department of Central Management Services
Local Government Health Plan
MEMBER ENROLLMENT FORM

MEMBER BIOGRAPHICAL INFORMATION (Please Print or Type)

Member SSN: ___________________ Org. Proc. Code: ________ Eff. Date of Add: ________________
Temporary SSN (Y/N) _____

Name: __________________________ _________________________ _________________________
(As it appears on SS Card) Last First Middle

Marital Status (S/M) _____ Birthdate (mm/dd/ccyy) ________________ Sex (M/F) __________

Medicare Status: (check one)
____1. Non Medicare
____2. Medicare Eligible 65+
____3. Medicare Ineligible 65+
____4. Medicare Disability
____5. End Stage Renal

If Medicare is 2, 4, 5 complete the following:
Part A (begin date) ______________________
Part B (begin date) ______________________
Part D (begin date) ______________________
Part A Free (Y/N) _____

If the member has a power of attorney, legal guardian or trustee, please complete the Other Addressee Information if the address is different than members.

Member Residential Address

____

____

City/State: ________________________
Zip: _____________________________
County: ___________________________
Send Mail to this Address (Y/N) _______

Other Addressee Information

Name: ______________________________

____

City/State: ___________________________
Zip: ________________________________
Addressee SSN: _______________________
Relationship: _________________________
Date of Relationship: ___________________
Send Mail to this Address (Y/N) ___________

MEMBER GROUP
Hire Date: ____________________ Type Enrollee: _____________ Full Time/Part Time % _____

SURVIVORS ONLY
SSN of deceased Member: ______________________ Relationship to Deceased Member (S/C) ____

Unit Name: ____
Member Name: ____________________________________
Member SSN: _____________________________________

UNIT INFORMATION

Work County Code: __________________ Distribution Code: __________________________________

COBRA ONLY

Original Member SSN: __________________________
1st COBRA Event _________ Date ____________________ 2nd COBRA Event ___________________

MEMBER HEALTH PLAN

Pre-Existing Months Applied	Carrier Code	PCP# (if applicable)
__________	_______	_____________________

COORDINATION OF BENEFITS – Other Group Health/Dental Insurance (Y/N) _________________
(If yes indicate below)

Plan	Begin Date	Carrier Name
Health	______________________	____________________________________
Dental	______________________	____________________________________

I authorize prevailing premiums (if any) to be deducted from my pay or annuity for the coverage I have selected. This authorization is to remain in effect until I provide written notice to the contrary. The statement and answers contained in this application are complete and true. I agree to abide by all appropriate rules and furnish any additional information if requested.

My signature confirms that I understand all above options selected. At all times this form must be signed by the member.

Required Member Signature: ______________________________________ Date: __________________

I have reviewed and explained all options available to the above member.

Health Plan Representative Signature: ____

Health Plan Representative Phone Number: ____

Date: __________________