PerfectHealth, The PerfectHealth Insurance Company, Staten Island, NY

Employee Enrollment and Change Form

1. Tell us about you

Last Name First Name M.I.

Home Address (Number and Street or P.O.Box / Apt. Number)

City State Zip Code

Home Telephone ( ) Work Telephone ( )

Email

Fax ( )

Marital Status ___ Single ___ Married ___ Divorced

__ Legally Separated __ Separated __ Widowed

2. New Enrollment

___ New Hire

___ Open enrollment

___ COBRA/Continuation

Date Of Qualifying Event

____/_____/_____

Reason _____

3. Enrollment Change

Change:

___ Address Change

___ Name Change

___ Other Change

Reason _____

Date _____/_____/_____

4. Where you work

Company Name | Occupation

Are you actively at work? ___ YES ___ NO (IF NO) REASON ___ SICK ___ INJURED ___ OTHER

Are you currently claiming Workers' Compensation Medical benefits? ___ Yes ___ No

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? YES NO

Do you work 30 or more hrs. per week? __ Yes __ No

Date of Full Time Hire ____/____/____ Date of Part Time Hire ____/_____/_____ Date of Rehire ____/_____/____

5. Medical Pre-Existing Condition Portability and Coordination of Benefits Statement

Did you or your dependents have prior medical coverage? __ YES __ NO

If Yes, Reason for loss of coverage ___ Quit Job ___ Employment Terminated ___ Divorce ___ Death ___ Other

I understand that in order to comply with Federal law regarding favorable tax treatment of a Medical Savings Account (MSA), I cannot nor can any covered dependents be covered by any other health plan. I and any covered dependents do not have any other medical coverage, including Medicare, in force that will be continued in addition to this PerfectHealth plan.

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? ✔ YES ✔ NO Have you or any covered dependent applied for Medicare/Medicaid disability? ✔ YES ✔ NO

Name (Self) | Are you actively at work? ___ YES ___ NO | Retirement Date _____/_____/_____

Medicare No. | Effective Dates: Medicare A (Hospital) | Medicare B (Medical)

Name (Dependent) | Are you actively at work? ___ YES ___ NO | Retirement Date _____/_____/_____

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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