

1. Tell us about you				
First Name	M.I.	Last Name		
Address Line 1 (Street Address – NO , P.O. Box)		Address Line 2 (Apartment No.)	City	State / Zip Code
Home Phone	Work Phone	Cell Phone	Fax Number	
Email	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			

2. New Enrollment				
<input type="checkbox"/> New Hire	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> COBRA/Continuation	Date of Qualifying Event / / Reason	

3. Enrollment Change				
<input type="checkbox"/> Address Change	<input type="checkbox"/> Name Change	<input type="checkbox"/> Other Change	Date / / Reason	

4. Where you work				
Company Name		Plan Number	Occupation	
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
Are you currently claiming Workers' Compensation Medical benefits?		<input type="checkbox"/> Yes <input type="checkbox"/> 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?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you work 30 or more hrs. per week?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Reason for loss of coverage	<input type="checkbox"/> Quit Job	<input type="checkbox"/> Employment Terminated <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Other

I understand that in order to comply with Federal law regarding favorable tax treatment of a Health Savings Account (HSA), 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									
	Last Name	MI	First Name	Add / Cancel	SS #	Date of Birth (mm/dd/yyyy)	Relationship Code	√ if Full Time Student Age 19 or Over.	Prior Carrier's Name
Self M F						/ /			
Spouse M F						/ /			
Depend. M F						/ /			
Depend. M F						/ /			
Depend. M F						/ /			

Relationship Codes: 001 Spouse 002 Child 003 Student* 004 Disabled* 005 Stepchild* 006 Legal Guardianship* *Documentation Required

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)
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 certify that I elect to enroll myself and the family members (dependents) indicated on this form. I certify that all dependents listed on this form are eligible for benefits and coverage under the terms of the PerfectHealth Plan. I acknowledge that I understand that PerfectHealth has no liability to provide coverage for ineligible dependents. 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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