



**PIEDMONT COMMUNITY HEALTH PLAN
ENROLLMENT/CHANGE FORM**

Please Check
Option – High Low

THIS SECTION MUST BE COMPLETED BY YOUR EMPLOYER

Employer Verification Signature _____ Date _____ Employee Only

ENROLLMENT TERMINATION COVERAGE CHANGE COBRA _____

New Address/Telephone No. New Name: Give Previous Name _____

Add Dependent(s) Family

Group Number **52030** - _____ Effective Date ____ / ____ / ____ Remove Dependent(s)

COVERAGE WAIVER

I elect to waive coverage from my employer (employee represents that he/she is covered under another group health insurance program).

EMPLOYEE INFORMATION

LAST NAME	FIRST	MIDDLE INIT.	SOCIAL SECURITY NUMBER
ADDRESS			EMPLOYER
CITY	STATE	ZIP	DEPT./LOCATION
HOME PHONE NO.	WORK PHONE NO.	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED	DATE EMPLOYED

INSTRUCTIONS: TO ENROLL YOU MUST COMPLETE THE FOLLOWING SECTION. IF YOU ARE ADDING NEWLY ELIGIBLE DEPENDENT(S), YOU NEED ONLY LIST THE DEPENDENT(S) YOU ARE ADDING AT THIS TIME.

SUBSCRIBER AND DEPENDENT INFORMATION (Include only those dependents to be covered by PCHP)

LAST NAME	FIRST	MIDDLE INITIAL	DATE OF BIRTH (MO/DAY/YR)	SEX	SOCIAL SECURITY NUMBER
SUBSCRIBER					
SPOUSE					
DEPENDENT CHILD					
DEPENDENT CHILD					
DEPENDENT CHILD					

ARE YOU OR ANY FAMILY MEMBER(S) LISTED ABOVE COVERED BY ANOTHER HEALTH CARE PLAN WHILE ENROLLED IN PCHP? YES NO
IF YOU ANSWERED YES, PLEASE COMPLETE THE FOLLOWING: TYPE OF COVERAGE: HEALTH DENTAL OTHER

NAME OF OTHER INSURANCE COMPANY OR PLAN PROVIDING COVERAGE: _____ POLICY (OR CONTRACT) NUMBER _____

IF ADDING DEPENDENT(S), PLEASE INDICATE REASON:

MARRIAGE: DATE ____ / ____ / ____ NEWBORN ADOPTION CHANGE IN CUSTODY (SUPPORTING DOCUMENT MUST BE ATTACHED.)

COVERAGE TERMINATION

REMOVE THE FOLLOWING DEPENDENT(S) TERMINATE COVERAGE: LAST DATE OF EMPLOYMENT ____ / ____ / ____

LAST NAME	FIRST	MIDDLE INIT.	INDICATE REASON: <input type="checkbox"/> RETIRED <input type="checkbox"/> MOVED FROM AREA <input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> TRANSFERRING TO ANOTHER PLAN <input type="checkbox"/> DECEASED <input type="checkbox"/> OBTAINED OTHER INSURANCE <input type="checkbox"/> CHANGED EMPLOYMENT <input type="checkbox"/> NO LONGER ELIGIBLE <input type="checkbox"/> OTHER
SPOUSE			
DEPENDENT CHILD			
DEPENDENT CHILD			

I hereby apply for membership or request a change in membership in my coverage. I understand that my enrollment and benefits are in accordance with those described in the applicable plan document. I authorize 1) all health providers and insurers to furnish PCHP and 2) all health providers and PCHP to furnish to all insurers and health providers records concerning me or any member of my family for whom information is requested for any purpose required for the coverage of benefits including, but not limited to, the coordination of payments with other insurers or in connection with the provision of medical care. I understand that I or my authorized representative is entitled to receive a copy of this form containing this authorization for disclosure of information. A photographic copy of this authorization shall be as valid as the original. I authorize my employer to deduct from my wages the amount required (if any) to cover my contribution for coverage. I certify that all of the above information is correct. This authorization is valid for the duration of my coverage for health benefits through PCHP.

SUBSCRIBER'S SIGNATURE _____ **DATE** _____