Association Mutual Health Insurance Company-Employee Benefit Plan

Wells Fargo Insurance Services, 1753 Pinnacle Drive, 8th Floor, McLean, VA 22102 – **FAX 703-760-5687 EMAIL: amhic@wellsfargois.com**

AMHIC ENROLLMENT APPLICATION/CHANGE FORM

*** Benefit Manager Completes This Section**

Name of Association:					**Subgroup Number:**
New Enrollment	**Special Annual Enrollment**	**Enrollment Change**	**Name Change**	**Reinstatement**	**Rehire**
Effective Date		**Change Effective Date**		**Employee Hire Date**	
Authorized Benefit Manager's Signature:					**Date:**

*** (SECTION 1) EMPLOYEE INFORMATION: PLEASE PRINT - Include JR, SR, or numerical designation in the name under suffix.**

Print Last Name	Print First Name	MI	Suffix
Address	City/State/Zip Code		
Home Phone #:	Email:	Work Phone #:	

Social Security Number	Date of Birth	Gender	Marital Status	Date of Marriage
		Male Female	Single Married	

*** (SECTION 2) Complete this section if applying for DEPENDENT Coverage: List spouse and all eligible dependent children applying for coverage under this plan.**

ADD	DROP	Name	Gender		Select applicable coverage			Relationship to Applicant	Date of Birth (MM/DD/YY)	Social Security Number
			Male F	emale	Health	Dental	Vision			

Is Dependent Disabled? **YES** **NO** NAME Effective Date	Is Spouse Employed? YES NO
Is Dependent a Full Time College Student(s)? **YES** **NO** If yes, please complete an NCAS Student Certification Form. NAME: ____________________________ SCHOOL: __________________ Is dependent claimed as a deduction on your Federal Income Tax Form?	2nd Student Dependent: NAME: S CHOOL: Claimed as a deduction on your Federal Income Tax Form? **YES** **NO**

*** (SECTION 3) ELECTION OF COVERAGE: Check box to indicate directory choice & level of coverage for each option.**

(If you do not elect a network for your PPO or Network Only coverage, the coverage will be defaulted to the CareFirst Network)	**PPO Plan Check One:** **CareFirst** **One Net** **NCPPO** **PHCS**	**Network Only Plan Check One:** **Care First** **PHCS**	**Kaiser**	**MetLife Preferred Dental Plan Check One:** **Standard** **Premium**	**Legal Resources** (Additional application must be completed)	**UHC Vision Plan**

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***(SECTION 4) OTHER HEALTH INSURANCE INFORMATION:**

Are you or any of your dependents covered by any other Health Care Plan? **YES** **NO** If, YES, ALL QUESTIONS THAT APPLY MUST BE ANSWERED.

Name of Policyholder Relationship to You SS# of Covered Person: Date of Birth

Carrier Policy Number Effective Date

Type of Plan: Group Individual Medicare COPY OF CARD REQUIRED Medicaid Champus Other

Is the Covered Person retired? NO YES If YES, enter date of retirement: Cancellation date if applicable

***(SECTION 5) WAIVER FOR GROUP INSURANCE: Mandatory signature required below.**

I hereby decline coverage under my employer's group benefit plan(s).

Medical – PPO Medical – Network Only Kaiser Dental – MetLife Vision – UHC Legal

By selecting "decline coverage" I hereby waive coverage under my employer's group plan and understand that if I desire such coverage hereafter I may be required to furnish medical evidence of insurability.

Employee's Signature: ______________________ Date: ______________

I hereby apply for group benefits provided under my employer's group plan(s) and authorize payroll deduction, if required, for the cost of coverage. I certify that the information given on this enrollment form is complete and correct, and I understand that if the information is not complete and correct, this coverage could be retroactively terminated.

Employee's Signature ______________________ Date / /

Print Name ______________________