

ENROLLMENT APPLICATION

PLEASE FILL OUT COMPLETELY. AN INCOMPLETE FORM DELAYS PROCESSING.

Check either "yes" or "no" below, then sign and date at the bottom left. If you need extra space for any section, please attach any additional information.

Yes, I wish to enroll in CHA Health. I authorize my employer to deduct from my earnings my share of the payment for coverage, if any. I also understand that those who provide services to me under this Plan are not agents, representatives or employees of CHA Health. I understand that the benefits for which I (we) will be eligible are those described in the Certificate of Coverage.

No, I do not wish to enroll in the Plan, although it has currently been made available. I understand that if I and/or my dependents request coverage at a later time, I and/or my dependents must wait until my Group's next open enrollment period, unless there is a qualifying event.

Reason for declining coverage:

- Covered by my spouse's plan
- Covered by Medicare/Medicaid CHAMPUS/CHAMPVA
- Other (explain): _____

1	Name - Last First Middle Initial			Group Number *	Effective Date*	Plan Code*	Plan Selected:	
	Social Security Number		Birth Date	Employer Name				
	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married		Date Hired: / /		Status: <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> COBRA	
	Home Telephone		E-mail Address		Number of hours worked/week: _____			
	Home Address Number/Street				Job Title			
	City County State Zip Code				<input type="checkbox"/> New Employee <input type="checkbox"/> Special Enrollment <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Other: _____			
				Persons to be Covered <input type="checkbox"/> Employee <input type="checkbox"/> Employee & Child(ren) <input type="checkbox"/> Employee & Spouse (E+1) <input type="checkbox"/> Employee & Family				

2	List you and your dependents to be covered	Birth Date	Gender	Full Time Student*	Relationship (Example: Spouse)	Social Security Number	Primary Care Physician	PCP Number	Current PCP? Y/N
	Last Name First MI	Mo/Day/Yr	M/F	Y/N		Number	Last Name First		
	Employee								
	Spouse								
	Dependent								
	Dependent								
	Dependent								
	Dependent								

*** Verification of Full time Student Status required for ages 19 to 25. Submit with application.**

3	After enrolling in this Plan, will you or any of your dependents have any other health insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	If yes, please complete the following (including Medicare, individual, or group coverage).					
	Name of Policy Holder/Employer	Policy Number	Effective Date	Termination Date	Single/Family	Name and Address of Insurance Company
If covered under Medicare, give effective dates for : Part A Part B						

4	Prior Coverage: In order to give you credit towards the pre-existing condition exclusion, list all health insurance coverage you and your dependents have had for the past twelve months. Attach the "Certificate of Creditable Coverage" for each insurance listed (or mail to the CHA Health Enrollment Department).					
	Name of Policy Holder (Employer)	Policy Number	Effective Date	Termination Date	Single/Family	Name and Address of Insurance Company

Signature and Date Required

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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. (KRS 304.47-030)

Employee Signature	Date
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Group Signature	Date
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This application may be altered solely by the applicant or by his/her written consent, except that insertions may be made by the insurer for administrative purposes only and in such a manner as to indicate clearly that such insertion is not ascribed to the applicant.

* To be filled out by employer
 CHA HMO, Inc. dba CHA Health