



# ENROLLMENT APPLICATION/CHANGE FORM (KENTUCKY)

## TO BE COMPLETED BY EMPLOYER

## TO BE COMPLETED BY PLAN

Employer Name			Employer #			Group #			Plan Code _____			Subscriber# _____		
Effective Date Of Coverage Mo   Day   Yr			Date Of Employment Mo   Day   Yr			Type of Enrollment: <input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire <input type="checkbox"/> COBRA <input type="checkbox"/> Retiree			<input type="checkbox"/> HMO _____ <input type="checkbox"/> POS _____			Location _____ Policy Type _____ Network _____		

## CHANGE IN STATUS FOR EMPLOYEE & DEPENDENT FAMILY MEMBERS

<input type="checkbox"/> Adding dependent (list name(s) below) <input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Adoption (attach adoption decree) <input type="checkbox"/> New student (attach current class schedule)	<b>EFFECTIVE DATE OF CHANGE</b>   Mo   Day   Yr	<input type="checkbox"/> Name change Previous name _____ Current name _____	<input type="checkbox"/> Termination of employee coverage (check reason below) <input type="checkbox"/> Left employment <input type="checkbox"/> Moved out of area <input type="checkbox"/> Payroll deduction too high <input type="checkbox"/> Other insurance <input type="checkbox"/> Other reason (list here) _____
<input type="checkbox"/> Address change (list new address below)		<input type="checkbox"/> Deleting dependent(s) (list here with reason): _____	
<input type="checkbox"/> COBRA coverage (list name(s) below) <input type="checkbox"/> Original COBRA effective date _____			
<input type="checkbox"/> Conversion (list name(s) below)			
<input type="checkbox"/> State Continuation			
<input type="checkbox"/> Other			

Social Security No.		Employee's Last Name			First	Middle	Date of Birth Mo   Day   Yr		
Street Address				City	State	Zip	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		
E-Mail*			Home Phone		Work Phone			Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced	

\*By giving my e-mail address I authorize WHP to electronically send newsletters and other communication regarding my account via this internet address.

## EMPLOYEE & DEPENDENT FAMILY MEMBERS TO BE COVERED BY THE HEALTH PLAN

Name If last name different, please list full name.	Date of Birth Mo   Day   Yr	Sex	Relationship to Employee	Primary Care Physician Select One for Each Family Member	Have you been treated by this physician?	Is dependent a full-time student? <small>If Yes, attach required verification.</small>	Is dependent disabled?
EMPLOYEE NAME		<input type="checkbox"/> M <input type="checkbox"/> F	Employee		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
SPOUSE NAME		<input type="checkbox"/> M <input type="checkbox"/> F	Spouse		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
SS No. _____							
DEPENDENT		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
SS No. _____							
DEPENDENT		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
SS No. _____							
DEPENDENT		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
SS No. _____							

## ADDITIONAL COVERAGE INFORMATION - Must Be Completed if Adding Any Dependents

Are you, spouse, natural or stepchildren covered by another medical insurance plan?  Yes  No

If yes, please complete the following information:

Is spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, spouse's employer: _____						
Does spouse have medical coverage through employer? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Policyholder's Name		Policyholder's Date of Birth Mo   Day   Yr	Policyholder's Social Security No.	Policyholder's Employer		Policyholder's Work Phone
Insurance Company		List Family Members Covered Under This Policy			Relationship To Policyholder	
Policy Number						
Are you covered under Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list Medicare No. _____ Part A Effective Date: _____    Part B Effective Date: _____			Is your spouse covered under Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list Medicare No. _____ Part A Effective Date: _____    Part B Effective Date: _____			

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.

I understand that WHP may collect personal information about me from outside sources, and that both personal and privileged information may be collected and disclosed to outside parties without my authorization as permitted by law. By signing this Enrollment Form, I agree to abide by all of the terms, conditions, rights and responsibilities as defined in the WHP Member Handbook and Agreement. This authorization is valid for 24 months.

Employee's Signature _____ Date _____	Employer Approval _____ Date _____
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Welborn Health Plans ♦ 101 S.E. Third Street ♦ Evansville, Indiana 47708 ♦ (812) 426-6600 ♦ (800) 521-0265