



ENROLLMENT APPLICATION/CHANGE FORM

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"/> COBRA	<input type="checkbox"/> New Hire <input type="checkbox"/> Retiree	<input type="checkbox"/> HMO _____ <input type="checkbox"/> POS _____ <input type="checkbox"/> WHO _____
						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)	EFFECTIVE DATE OF CHANGE Mo Day Yr	<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"/> Name change Previous name _____ Current name _____	
<input type="checkbox"/> COBRA coverage (list name(s) below) <input type="checkbox"/> Original COBRA effective date _____	<input type="checkbox"/> Deleting dependent(s) (list here with reason): _____	
<input type="checkbox"/> Conversion (list name(s) below) _____		
<input type="checkbox"/> Other _____		

Social Security No.	Employee's Last Name	First	Middle	Date of Birth Mo Day Yr
Street Address			City	State Zip
E-Mail*		Home Phone	Work Phone	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
*By giving my e-mail address I authorize WHP to electronically send newsletters and other communication regarding my account via this internet address.				Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced

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? If Yes, attach required verification.	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? Yes No If yes, spouse's employer: _____

Does spouse have medical coverage through employer? Yes No

Policyholder's Name	Policyholder's Date of Birth Mo Day Yr	Policyholder's Social Security	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: _____		

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.

Employee's Signature _____ Date _____	Employer Approval _____ Date _____
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