

**APPLICATION FOR
 GROUP ENROLLMENT**

EMPLOYER: PLEASE COMPLETE THIS SECTION

Group Number _____
 Firm's Legal Name _____
 Reason For Adding _____

Open Enrollment
 New Employee
 Information Change
 Adding Dependent(s)

Terminate Coverage for:
 Subscriber and Dependents
 Dependent(s) only

Transfer to COBRA
 Start Date _____
 18 months
 36 months
EFFECTIVE DATE OF CHANGE _____

EMPLOYEE COMPLETE THE FOLLOWING NON-SHADED AREAS. PLEASE PRINT.

Employee Name _____ Marital Status: Married Date Married ___/___/___ Single Original Date of Hire ___/___/___
 Resident Address _____ Home Phone _____ Date of Rehire ___/___/___
 City _____ State _____ Zip _____ - _____ County _____ Work Phone _____ Date Transferred From
 Part to Full Time ___/___/___
 Medicare Number _____ Former Name of Applicant or Spouse _____ Hours Worked Per Week _____

EFF. DATE	CHECK ONE		List Persons To Be Covered (Please Print) LAST FIRST M.	SOCIAL SECURITY #	SEX	DATE OF BIRTH MO-DY-YR
	ADD	REMOVE				
			Employee			/ /
			Spouse 1			/ /
			Dependents 2			/ /
			3			/ /
			4			/ /
			5			/ /

ADDITIONAL HEALTH BENEFITS INFORMATION

Please list the name of the previous health insurance company for you, your spouse and/or dependents.

Date coverage began: _____ Date coverage ended: _____
 Are you, your spouse and/or dependents covered by other health insurance or Medicare? Yes No
 Medicare Number: _____
 Name of other insurance company: _____
 Address _____ Telephone No. () _____
 Subscriber No. _____ Group Plan No. _____
 Subscriber/Member Policy No. _____ Effective Date of Coverage _____
 Names of persons covered by this carrier:
 _____ Birthdate _____
 _____ Birthdate _____
 _____ Birthdate _____
 _____ Birthdate _____

DEPENDENT ELIGIBILITY INFORMATION

If you have listed a dependent child over the age of 18 years, please answer the questions below about your dependent:

1. Married? Yes No
2. Income tax dependent? Yes No
3. Resides regularly as a member of your household? Yes No
4. Full-time student at an accredited school? Yes No

If full-time student, give name of college, university or vocational school dependent is attending:

Your dependent's eligibility will be determined upon our receipt of your completed questionnaire. If your group medical contract specifies a limiting age for dependents, Group Health Options, Inc. (GHO) reserves the right to request proof of school enrollment status. If your dependent is determined ineligible for medical coverage under your group contract, you will be notified in writing.

SUBSCRIBER'S SIGNATURE _____ (Coverage cannot be granted without signature) DATE _____

Please notify GHO in writing of any changes to address or family status.