

ENROLLMENT APPLICATION



MEDICAL ASSOCIATES
HEALTH PLANS®

1605 Associates Drive, P.O. Box 5002
Dubuque, Iowa 52004-5002
(563) 584-4885 or Toll Free 1-866-821-1365
Fax: 563-584-4760
E-mail: memberservices@mahealthcare.com

Effective Date ____/____/____

PRESS HARD
YOU ARE MAKING 3 COPIES

NEW ENROLLMENT or
 CHANGE NOTICE

- | | |
|---|---|
| <input type="checkbox"/> Add dependents-list dependent(s) to add in Section B
<input type="checkbox"/> Remove dependents-list dependent(s) to remove in Section B
<input type="checkbox"/> Reason for adding or deleting members _____
<input type="checkbox"/> Effective Date of Change _____
<input type="checkbox"/> Cancel Coverage Effective _____
<input type="checkbox"/> COBRA | <input type="checkbox"/> Change Name from _____
(list new name in Section A or B)
<input type="checkbox"/> Change of Address _____
(list new address in Section A)
<input type="checkbox"/> Other (specify) _____ |
|---|---|

CHANGE COVERAGE TO:

TYPE OF COVERAGE:

- Single
 Employee + Spouse
 Employee + Child
 Employee + Children
 Family

THIS APPLICATION MUST BE COMPLETED IN FULL FOR ALL NEW ENROLLMENTS

SECTION A: SUBSCRIBER DATA

EMPLOYER NAME		DATE EMPLOYED	DIVISION #	MARITAL STATUS	
				<input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Legally Separated	
LAST NAME	MAIDEN NAME	FIRST NAME	INITIAL		
STREET ADDRESS		CITY	STATE	ZIP	
COUNTY	SOCIAL SECURITY NO.	PHONE NUMBER ()	DATE OF BIRTH ____/____/____	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	

SECTION B: SPOUSE/DEPENDENT DATA

NAME (Last, First, Middle Initial)	DATE OF BIRTH	SEX	FULL-TIME STUDENT?	SOCIAL SECURITY NUMBER
SPOUSE				
DEPENDENT				
DEPENDENT				
DEPENDENT				
DEPENDENT				
DEPENDENT				

SECTION C: COORDINATION OF BENEFITS

IS YOUR SPOUSE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO		NAME OF EMPLOYER _____		CITY/STATE OF THE EMPLOYER _____	
IS YOUR SPOUSE COVERED UNDER A GROUP HEALTH POLICY WITH THAT EMPLOYER <input type="checkbox"/> YES <input type="checkbox"/> NO		ARE YOU AND/OR ANY DEPENDENT CHILDREN ALSO COVERED UNDER YOUR SPOUSE'S POLICY? <input type="checkbox"/> YES <input type="checkbox"/> NO			
IF "YES" TO THE ABOVE QUESTION, WHAT IS THE NAME OF THE INSURANCE COMPANY, AND LIST FIRST NAMES OF ALL PERSONS COVERED (if there is a court-ordered document, please send a copy):			ARE ANY OF THE FOLLOWING ELIGIBLE FOR MEDICARE? <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT		
WILL YOUR SPOUSE'S COVERAGE REMAIN IN EFFECT WHEN THIS COVERAGE IS EFFECTIVE? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, WHAT IS THE NAME OF THE INSURANCE COMPANY?		IF NO, WHEN WILL COVERAGE TERMINATE? ____/____/____	

To the best of my knowledge, the above information is complete and true, and I understand that falsification by me will allow my employer's group health plan to recover payments made, cancel my coverage and/or refuse payment of claims. Updates or additions to this information may be required periodically. I hereby request the amount(s) and Forms of Coverage for which I am or may become eligible and hereby authorize my employer to deduct any required contributions from my earnings (pre-tax, if applicable). By signing, I authorize all physicians, Ph.Ds, hospitals, druggists and all agencies including other claim administrators, to furnish to MAHP full information pertaining to the diagnosis and treatment of medical, mental health, and drug and alcohol conditions. I understand that the purpose or need for this disclosure is to verify eligibility of benefits, I also understand that this consent is subject to revocation at any time through a written submission to MAHP.

Signature _____ Date _____

MEDICAL ASSOCIATES HEALTH PLAN, INC.