

NAME OF EMPLOYER				GROUP NUMBER	SUB-GROUP	PRODUCT					
<input type="checkbox"/> New Hire	<input type="checkbox"/> Late Enrollment	<input type="checkbox"/> Retiree	<input type="checkbox"/> Continuation (Begin Date)	QUALIFYING EVENT		Date of Full-Time Employment		Coverage Effective Date			
<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Life Event	<input type="checkbox"/> Early Retiree				Month	Day	Year	Month	Day	Year

EMPLOYEE'S LAST NAME (LEGAL NAME)	FIRST NAME	M.I.	DATE OF BIRTH			SOCIAL SECURITY NUMBER		
			Month	Day	Year			

STREET ADDRESS/APT. NO. _____

CITY	STATE	ZIP	COUNTY
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EMPLOYEE'S TELEPHONE	E-MAIL ADDRESS	<input type="checkbox"/> MALE	MARITAL STATUS
HOME () BUSINESS ()		<input type="checkbox"/> FEMALE	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED

Do you or any family members listed below have other coverage in addition to this plan? NO YES - **Type:** Medical Dental
 If yes, name(s) _____ Single coverage or Family coverage Place of employment _____
 Name of insurance company _____ Group number _____

Are you covered by Medicare Part A and/or Part B:? NO YES - (Attach a copy of Medicare card) Effect. date: Part A _____ Part B _____

Is your spouse covered by Medicare Part A and/or Part B:? NO YES - (Attach a copy of Medicare card) Eff. date: Part A _____ Part B _____

Do you or any family member included on this enrollment form currently have or have you had continuous health coverage for the last 12 months (18 months for late enrollees)? NO YES - please list carrier name, effective date and termination date _____

I ACCEPT FULL COVERAGE for myself and eligible dependents as indicated below:
 Medical: Self Spouse Children **Dental:** Self Spouse Children
 I DECLINE COVERAGE due to: Other group coverage* Individual coverage* _____
 *List carrier name _____ Other reason _____

If you are declining major medical expense coverage for yourself or your dependents (including your spouse) because of other medical insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request coverage within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after marriage, birth, adoption, or placement for adoption.

I understand, subject to the terms and conditions of PCHP, if I or any dependents enroll at a later date, PCHP reserves the right to impose a preexisting condition limitation, subject to credit given for prior continuous qualifying coverage. I freely and voluntarily waive health care coverage through PCHP.
 Date: _____ Employee Signature: _____

FILL IN THE FOLLOWING INFORMATION FOR EACH PERSON TO BE COVERED

LAST NAME ONLY IF DIFFERENT FROM ABOVE	FIRST NAME	MIDDLE INITIAL	RELATIONSHIP	SEX (M or F)	DATE OF BIRTH			SOCIAL SECURITY NO.
					Month	Day	Year	

Do all of the dependent(s) listed above reside at the same address as the employee? YES NO

If no, list dependent(s) name and address _____

If last name is different for dependents, please explain why _____

Are any of the above listed dependent(s) age 19 or older, students? YES NO

If yes, please indicate the name, school attending and status

NAME	SCHOOL	STATUS
_____	_____	<input type="checkbox"/> Part-Time <input type="checkbox"/> Full-Time
_____	_____	<input type="checkbox"/> Part-Time <input type="checkbox"/> Full-Time

I represent that the answers to the questions and statements made on this form are true and complete. If my answers are incorrect or untrue, PCHP has the right to reduce or deny benefits or rescind coverage. I authorize any physician, medical practitioner, hospital, clinic, veterans administration facility, or other medically related facility having information available as to diagnosis, treatment and prognosis with respect to any physical or mental conditions and/or treatment of me or my covered dependents to give to PCHP any and all of the information requested. This authorization excludes the release of information about HIV (AIDS virus) tests which were administered: 1) to a criminal offender or crime victim as a result of a crime that was reported to the police; 2) to a patient who received the services of emergency medical personnel at a hospital or medical facility; or 3) to emergency medical personnel who were tested as a result of performing emergency medical services.
 I agree that a photographic copy of this authorization shall be as valid as the original. I agree that this authorization shall be valid for 26 months from the date shown below.

I UNDERSTAND THAT PROVIDING FALSE INFORMATION OR OMISSION OF RELEVANT INFORMATION IN THIS APPLICATION MAY RESULT IN THE DENIAL OF CLAIM(S) OR CANCELLATION OF COVERAGE.

X	Month Day Year	X	Month Day Year
SIGNATURE OF EMPLOYEE (required)	DATE SIGNED	SIGNATURE OF EMPLOYER	DATE SIGNED

EMPLOYEE - COMPLETE ALL UNSHADED AREAS.