Employee Enrollment Form

AMERICAN SPECIALTY HEALTH INSURANCE COMPANY·P.O. BOX 509002·SAN DIEGO, CA 92150-9002· ATTENTION: ENROLLMENT DEPARTMENT·PHONE (800) 848-3555·Fax: (619) 557-2343

REASON FOR SUBMISSION

☐ New application ☐ Change of address/name ☐ Add dependent ☐ Delete dependent (list name below) ☐ Other: ___________________________________

EMPLOYEE INFORMATION

Last name	First name	MI	Home phone ( )	Work phone ( )	E-mail
Address		City	State	Zip	Sex ☐ M ☐ F / Birth date
Employer name	Group #	Health plan/Insurance carrier	Member ID	Effective date	Social Security number

ELIGIBLE DEPENDENTS TO BE ENROLLED

Spouse ☐ M ☐ F	Last name	First name	MI	Birth date	E-mail
[Domestic Partner ☐ M ☐ F	Last name	First name	MI	Birth date	E-mail
Dependent ☐ M ☐ F	Last name	First name	MI	Birth date	E-mail
Address (If different from above)		City	State	Zip	Phone Number (If different from above)
Dependent ☐ M ☐ F	Last name	First name	MI	Birth date	E-mail
Address (If different from above)		City	State	Zip	Phone Number (If different from above)
Dependent ☐ M ☐ F	Last name	First name	MI	Birth date	E-mail
Address (If different from above)		City	State	Zip	Phone Number (If different from above)

Are you capable of understanding communications written in English?	☐ Yes	☐ No	If not, what is your primary language?____________________
[Is a domestic partner listed above?	☐ Yes	☐ No	(If yes, please attach verification of the domestic partnership (e.g., a copy of your Declaration of Domestic Partnership.)]
If additional Dependents, please attach an additional application form			
Are any of the above dependents a full or part time College or University student?	☐ Yes	☐ No	(If yes, please attach a Student Verification Form)
Are any of the above dependents that are over 19 disabled?	☐ Yes	☐ No	(If yes, please attach a completed Disability Certification form)
Are any of the above dependents covered due to a court order?	☐ Yes	☐ No	(If yes, please attach a copy of the Court Order)
Do you or anyone listed have any other complementary benefits? [See Coverage Type below]	☐ Yes	☐ No	(If yes, complete section below)

Name(s)	Other employer name & address		Insurance ID/SSN
Insurance company name	Policy number	Effective date	Coverage type (check applicable coverage type): ☐ Chiropractic ☐ Acupuncture ☐ Massage Therapy ☐ Dietetics
Name(s)	Other employer name & address		Insurance ID/SSN
Insurance company name	Policy number	Effective date	Coverage type (check applicable coverage type): ☐ Chiropractic ☐ Acupuncture ☐ Massage Therapy ☐ Dietetics

OTHER INFORMATION

I authorize the deduction from my earnings of the required contribution toward the cost of insurance. I agree to allow any health care provider and any firm or insurer to release my personal information, including medical record information, to American Specialty Health Insurance Company (ASHIC) and its contracted health professionals, vendors, representatives and/or agents to fulfill their obligations under the terms of the plan under which I am enrolling myself and my dependents. I attest that the information provided herein is true and accurate to the best of my knowledge. I understand any false statements may invalidate coverage. I understand that this Authorization is valid for the term of coverage under the plan. I understand that I may revoke this Authorization at any time by contacting ASHIC and making a revocation. I understand that I am entitled to receive a copy of this form. [Warning: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony.]

- I have read, understand and agree to the terms and conditions on this form.
- As a parent or guardian, I authorize the participation of any enrollee under the age of 18.

Signature:		Date:	