



PLEASE BE SURE TO FILL OUT AND SIGN THIS FORM,
and return to your Human Resources Department.

Enrollment Form

HOURLY SALARIED 90-DAY CONTINUATION COBRA

Section A: EMPLOYEE INFORMATION			EMPLOYEE NAME (LAST, FIRST, M.I.)		SOCIAL SECURITY NUMBER		EFFECTIVE DATE		
Address (number)		(street)		(city)		(state)		(zip)	
County			Home Phone			Work Phone			
Company Name and Address							Date of Hire		
Marital Status						Spouse's Name			
<input type="checkbox"/> Single		<input type="checkbox"/> Married		<input type="checkbox"/> Divorced		<input type="checkbox"/> Widowed			
Does your spouse have other health coverage?				Name and address of Spouse's Employer:					
<input type="checkbox"/> Yes		<input type="checkbox"/> No		If yes, see Section D					
My primary language is:			<input type="checkbox"/> English		<input type="checkbox"/> Spanish		<input type="checkbox"/> Other:		
Section B: MEDICAL BENEFIT PLAN						PLAN: (CHECK ONE)		PLAN #	
MEMBERSHIP TYPE: (CHECK ONE)									
<input type="checkbox"/> Single		<input type="checkbox"/> Employee & Spouse		<input type="checkbox"/> Employee & Child(ren)		<input type="checkbox"/> Family			
						<input type="checkbox"/> HMO		<input type="checkbox"/> Point of Service	
						<input type="checkbox"/> Consumer Choice Option		<input type="checkbox"/> PPO	
Section C: LIST ALL PERSONS TO BE ENROLLED ON THE LINES BELOW.						You MUST select a Primary Care Physician			
<i>For more than four children, attach a separate sheet.</i>						For each enrolled member of your family.			
Please complete all of the following information for you and your family members to be covered.									
	Social Security #	Last Name, First, M.I.		Sex M / F	Birthdate MM DD YY	Height	Weight	PRIMARY CARE PHYSICIAN *Required Field Please check box if you are a current patient.	✓
EMPLOYEE									
SPOUSE									
CHILD 1									
CHILD 2									
CHILD 3									
CHILD 4									
COMPLETE IF ENROLLING A HANDICAPPED DEPENDENT AGE 19 OR OVER:									
Handicapped Dependent's (Last, First, M.I.) (Attach doctor's statement)									
Section D: Other Coverage Information (COB) Please complete the following if you or another family member is covered under another group plan, HMO or Medicare									
Policy Holder Name		Effective Date of Policy		Policy or I.D. #		Name of Group (Employer)		Type of Contract <input type="checkbox"/> Individual <input type="checkbox"/> Family	
Name of Insurance Company				Address:					
Are You Eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No				Is Your Spouse Eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<input type="checkbox"/> Part A/Effective Date: _____				<input type="checkbox"/> Part A/Effective Date: _____					
<input type="checkbox"/> Part B/Effective Date: _____				<input type="checkbox"/> Part B/Effective Date: _____					
Medicare HIC# _____ - _____ - _____				Medicare HIC# _____ - _____ - _____					
Is Medicare coverage related to end stage renal disease?				Is Medicare coverage related to end stage renal disease?					
<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No					

Health Questions: All of the following questions must be answered with respect to each person for whom you are applying for coverage. Indicate if anyone listed on this application within the past 10 years had medical advice, treatment, or if you have reasons to know of health problems in regard to the following. Questions answered Yes must be explained in detail in the space(s) provided on page three.

1. Circulatory System:		Yes	No	6. Endocrine System:		Yes	No
Heart Attack				Diabetes-Insulin dependant, Non-Insulin dependant			
Coronary artery disease (angina pectoris, coronary insufficiency, thrombosis, occlusion)				Thyroid disease-benign, Hyperthyroidism, Hypothyroidism			
Pacemaker				Enlargement of the lymph-nodes			
Angioplasty or coronary artery by-pass (CABG)				Connective tissue disorder			
High blood pressure				Abnormal production of growth hormones			
Stroke				7. Muscular or Skeletal System:		Yes	No
Elevated cholesterol and/or triglyceride levels				Rheumatoid or Psoriatic arthritis			
Anemia or blood disorder				Osteoarthritis			
Peripheral Vascular Disease (PVD)				Fibromyalgia			
Congestive heart failure				Back disorder or chronic back pain			
Congenital heart disease (abnormality at birth)				Joint disorder			
2. Genitourinary System:		Yes	No	Chronic fatigue syndrome			
Infertility				Carpal tunnel syndrome			
Genital disorder				8. Cancer:		Yes	No
Menstrual disorder for which you take an injection medicine				Cancer-local, regional or distant, gland/organ affected:			
Pregnancy complications (premature birth, miscarriage, c-section)				Tumor-malignant or benign			
Bladder disorder				Carcinoma in situ (localized malignant lesion)			
Prostate disorder				Other:			
Do you have any degree of Kidney impairment				Karposi's sarcoma			
3. Respiratory System:		Yes	No	9. Behavioral Health:		Yes	No
Asthma				Psychotic disorder (schizophrenia, paranoia, manic or severe depression)			
Allergies-seasonal, Immunotherapy required, Anaphylaxis reaction requiring epinephrine				Neurotic disorder (anxiety, panic disorders, obsessive compulsive disorder)			
Emphysema				Attention deficit disorder			
Sinus or nasal disorder				Suicide attempt			
Lung disease or disorder				Alcohol or Drug Abuse			
4. Nervous System:		Yes	No	Depression – situational, post partum			
Migraines, headaches of any type				10. Ear or Eye:		Yes	No
Multiple Sclerosis				Eye disorder			
Parkinson's disease				Ear disorder			
5. Digestive System:		Yes	No	11. Other:		Yes	No
Ulcers				Hernia			
Liver/Pancreas disorder, Hepatitis				Organ or other type of transplant or implant			
Intestinal disorder (Colitis, Crohn's disease)				Breast disorder			
Rectal disorder				Lupus			
Acid reflux/Heartburn for which you take prescription medication				Allergy - Non-Respiratory please list:			

12. Has any person on this application, within the last five years, been hospital-confined or had surgery? Yes No

13. Has any person on this application been advised to undergo a surgical operation which was not performed? Yes No

14. Has any person on this application been advised to undergo surgery within the next six months? Yes No

15. Is any person on this application currently pregnant? If yes, please indicate anticipated date of delivery Yes No

16. Is any person on this application currently taking any medication, undergoing treatment, or therapy? Yes No

Please list all medication taken within the last 12 months.

17. Has any person on this application smoked within the last five years? Yes No

18. Has any person on this application been told he/she had an infection/immune deficiency disorder, Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), sexually transmitted diseases or Lyme disease? Yes No

Please complete if ANY of the previous questions were answered “YES”. Please print clearly and include ALL information required. This information will be used to evaluate medical risk not eligibility. If additional space is needed please attach a separate sheet.

Health Question#	Name of Person Treated	Name of illness or disorder	Type of treatment received	Treatment dates		Medications/Dosage/Frequency (i.e., Maxalt/5 mg/daily)
				From:	To:	

RIGHTS AND OBLIGATIONS

I hereby apply for myself and my eligible family members for the medical coverage specified in the Contract between my Employer and Athens Area Health Plan Select, Inc. (hereafter referred to as the Company).

I understand and agree the effective date of coverage will be governed by the stipulations of the Group Application and the Group Healthcare Contract under which this application is made. I understand that membership will continue according to the terms of the contract between my Employer and the Company. I hereby authorize my Employer to periodically deduct any charge due from me hereunder and to remit it to the Company along with any contribution due from my Employer. I understand and agree that the Company reserves the right to change the subscription charges due from this coverage and to increase or decrease the benefits by giving sixty (60) days written notice to my Employer.

SUMMARY OF REQUIRED NOTICES

PRIVACY ACT. Georgia state law establishes standards for the collection, use and disclosure of information gathered in connection with insurance transactions. The application attached to this notice contains specific personal questions about you and your family members. The information provided by you is used to determine your eligibility for coverage under this plan. We are required to notify you that personal information may be collected from persons other than you or other individuals proposed for coverage. An investigative consumer report may be made to help us obtain additional medical data from physicians or hospitals.

DATA CONFIDENTIALITY. We are required by law to keep your data confidential. It will only be disclosed to employees, authorized agents, and business associates of Athens Area Health Plan Select, Inc. in accordance with applicable law. Your data may in certain circumstances be disclosed without your authorization. We may provide your data to authorized federal or state agencies, consumer investigative service bureaus or others as required by our standard business practice or if required by law.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA). Athens Area Health Plan Select, Inc. will maintain all protected health information in compliance with federal and state laws. You have specific rights under this federal law. Please review the Notice of Privacy Practices, which will be provided to you in your enrollment package for further details or contact our Member Services Department, 295 W. Clayton Street, Athens, Georgia 30601.

I declare that all statements and information made are complete and true to the best of my knowledge. I understand that any fraudulent or intentional misstatements of material facts may void all coverage applied for on any member included on this enrollment application for a period of up to two (2) years from the contract effective date.

By my signature below, I acknowledge that Athens Area Health Plan Select, Inc. has informed me of the following prior to my enrollment in their health plan:

1. Number, mix and location of network/participating health care providers;
2. Limitations on choices of network/participating health care providers; and
3. Disclosure of contractual relationship between network/participating providers and Athens Area Health Plan Select, Inc.

IMPORTANT NOTICE AND AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information regarding your insurability will be treated as confidential. I authorize the use/disclosure of any and all individually identifiable health information, including medical records, reports, pharmaceutical records, diagnostic testing, lab work, and other medical information about me as described below:

I understand that the following parties may need to collect information on me in regard to the proposed: Athens Area Health Plan Select, Inc., and its reinsurers, any insurance support organization, any consumer reporting agency, and all persons authorized to represent these organizations for this purpose. I authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, or medically related facility, or other organization, institution or person that has knowledge or records of me and my health to disclose information as allowed or required by law.

I understand that this authorization is needed for the purpose of gathering information for making eligibility, underwriting and risk rating determinations, to locate or underwrite insurance for me, or to determine whether a valid claim for benefits has been made. I understand that the person I am authorizing to use/disclose the information may receive compensation for doing so.

I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I may inspect or copy any information used/disclosed under this authorization.

I understand that I can revoke this authorization at any time by giving written notice to the Insurance Company, Athens Area Health Plan Select, Inc., 295 West Clayton Street, Athens, Georgia 30601. I also understand that my revocation will not affect the rights of any individual who has acted in reliance on the authorization prior to receiving notice of my revocation. Unless revoked earlier, this authorization will be valid for (30) thirty months after the date it is signed.

Date

Signature of Proposed Insured or Authorized Person

Date

Signature of Other Proposed Insured

Date

Signature of Dependent (age 18 or older)

Date

Signature of Dependent (age 18 or older)

Date

Signature of Authorized Person on behalf of Proposed Insured