



Capital Health  
PLAN

<b>CHP USE ONLY:</b>	Effective Date:
ID#:	Group #:

### ENROLLMENT APPLICATION

Applying for New Membership:  Transferring Present Membership:  OR Re-Enrolling:  ID#:

Type of Coverage Applying For:  Single  Employee & Spouse  Employee & Children  Family

1. Last Name:	2. First Name:	3. M.I.:
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4. Name of Employer:	5. Hire Date:	6. Type of Employment: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time: _____ Hours per week
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7. I do not wish to apply for CHP Coverage/Membership. I understand that, if I decide to apply at a later time, Coverage/Membership may not be available until the next open enrollment period, or I may be asked to provide evidence of insurability. **IF YOU DECLINE COVERAGE, PLEASE DO NOT COMPLETE THE REST OF THIS FORM.**

Signature of Applicant/Employee: \_\_\_\_\_ Date: \_\_\_\_\_

8. Physical Street Address:

Street City State Zip Code County

9. Mailing Address: (If different from above)

Street City State Zip Code County

10. DOB:	11. SSN:	12. Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	13. Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated	14. Work Phone #:	15. Home Phone #:
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16. LIST ELIGIBLE FAMILY MEMBERS TO BE COVERED PLEASE PRINT  
A certified copy of the court order must be attached for dependents in court-ordered custody or guardianship of the certificate holder. If more space is required, attach a separate page with additional information.

Please provide (on the reverse side of this form) an alternate address for any dependent not living with you.

17. Applicant's Primary Care Physician Selection:	Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
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18. Relationship To You	19. First Name & Middle Initial Last Name (if not the same)	20. Social Security Number	21. Date of Birth	22. Supported By You	Living with You	Full-Time/Part-Time Student	Disabled	23. Primary Care Physician	Current Patient?
Spouse <input type="checkbox"/> Male <input type="checkbox"/> Female									<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> My Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other <input checked="" type="checkbox"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> My Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other <input checked="" type="checkbox"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> My Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other <input checked="" type="checkbox"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

Supporting documentation required.  
Are you or any member of your family covered by any other health plan or health insurance?  Yes  No  
If yes, complete the appropriate section(s) below. If more space is needed, attach a separate sheet with additional information.  
**Note: If you or your dependents currently have coverage, or had any coverage within the past 63 days that this coverage replaces, please fill out and attach a Prior/Concurrent Option Coverage Affidavit form, or attach a Certificate of Creditable Coverage.**

24. OTHER HEALTH PLAN INSURANCE		25. MEDICARE	
Insured Member's Name:	Date of Birth:	Beneficiary Name:	Beneficiary Name:
Employment Status: <input type="checkbox"/> Active <input type="checkbox"/> Retired	Name of Employer:	Entitlement Reason: <input type="checkbox"/> Age 65 or Older <input type="checkbox"/> End Stage Renal Disease <input type="checkbox"/> Other Disability	Entitlement Reason: <input type="checkbox"/> Age 65 or Older <input type="checkbox"/> End Stage Renal Disease <input type="checkbox"/> Other Disability
Type of coverage: <input type="checkbox"/> Single <input type="checkbox"/> Family	Policy #:	Effective Date:	Medicare #:
Name of Insurance Company:	Phone:	Part A Effective Date:	Part A Effective Date:
Does the above insurance cover "all" family members including yourself? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If no, please list dependents not covered on a separate sheet.</b>	Part B Effective Date:	Part B Effective Date:	Part B Effective Date:

ACCEPTANCE OF COVERAGE/MEMBERSHIP: I have read and understand the Acceptance of Any Coverage/Membership on the reverse side of this form.

Signature of Applicant/Employee: \_\_\_\_\_ Date: \_\_\_\_\_

Employer Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Applicant's Proposed Coverage Effective Date: \_\_\_\_\_

**ACCEPTANCE OF ANY COVERAGE/MEMBERSHIP –  
READ BEFORE SIGNING ON THE FRONT OF THIS FORM**

I hereby apply for the coverage/membership selected on the front side of this form. My employer has selected the coverage/membership through Capital Health Plan, Inc., d/b/a/ Capital Health Plan (CHP). I authorize my employer to deduct from my earnings my premium contribution, if any. I understand all of the following:

1. If my coverage/membership is to be issued and continued, I must meet all of the requirements of the group contract.
2. If my dependents' coverage/membership, if any, is to be issued and continued, my dependents must meet all of the requirements of the group contract.
3. If I must pay part or all of the premium, coverage/membership shall not become effective until CHP accepts this application and assigns an effective date.

I agree that any controversy or dispute between CHP and myself or my dependents shall be subject to the complaint and grievance procedures, including binding arbitration, set forth in the CHP Member Handbook.

I understand that my employer is not an agent of CHP. I also understand that my employer is responsible for notifying employees of all: 1) effective dates; 2) termination dates; 3) conversion, COBRA, or ERISA rights and responsibilities; and, 4) other matters pertaining to coverage/membership under the group contract.

I authorize persons or entities that have any medical or other records or knowledge of me or my eligible dependents to release that information to CHP. These persons or entities include any: 1) licensed physician; 2) medical practitioner; 3) hospital; 4) clinic or other medical or medically related provider; 5) insurer; 6) employer; or, 7) other organization, institution, or person. This information also may be released to any affiliated or reinsurance carrier. I also authorize CHP, at its sole discretion and consistent with law, to use and disclose financial and health information obtained about me and/or my eligible family members for treatment, payment, and/or health care operations purposes, including coordination of benefits, if needed. This routine consent covers future, known, or routine needs for personal health information. These routine needs include treatment, coordination of care, quality measurement, including surveys of members, accreditation, and billing. These releases specifically include, but are not limited to, authorization to release: 1) any and all medical records; and, 2) information about, associated with, or with reference to certain conditions. This information consists of specific medical information on me or my dependents, including, but not limited to, authorization to release: 1) any and all medical records; and, 2) information about certain conditions. These conditions include: 1) exposure to HIV infection; 2) ARC; 3) alcohol or drug dependency; and, 4) mental and nervous disorders. I understand that CHP shares no member-identifiable information with employers unless the member provides specific consent.

When an overpayment is made, I authorize CHP to recover the excess from any person or entity that received it.

I acknowledge that, if I apply for CHP coverage/membership at a later date, coverage/membership may not be available until the next open enrollment. Also, I may be required to furnish evidence of insurability.

I acknowledge that CHP coverage/membership is contingent on the complete, accurate disclosure of the information requested on this form. I represent that the statements on this application are true and complete. I understand and agree that any misstatements or omissions may result in denial of benefits and/or termination of coverage/membership. I agree to be bound by the terms and conditions of the group contract. I understand that this application is part of the group contract.

**DEPENDENT'S ALTERNATE ADDRESS INFORMATION:**

NAME	ALTERNATE ADDRESS

**FRAUD 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 of the third degree.**