SOUTH CENTRAL MINNESOTA ELECTRICAL WORKERS FAMILY HEALTH PLAN

ENROLLMENT FORM - ADD/CHANGE FORM

☐ Initial Enrollment ☐ Adding Dependent Effective Date:_____

PARTICIPANT INFORMATION

Name:_____

Social Security Number: _____ ____ Male ____ Female

Date of Birth: _____ Email Address: _____

Home Phone #: _____ Cell Phone #: _____

Address: _____
Street City State Zip Code

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated Date of Marriage: ____/____/____

DEPENDENT INFORMATION

Complete for all family members applying for coverage. If coverage for dependents is being applied for, all eligible dependents must be listed. If a particular line is not applicable, write N/A. Additional information may be required.

Full Legal Name (Last, First, Middle)	Relationship Sex	Date of Birth	Soc. Sec. Number (Required)	Type of Dependent Child* (see codes below)
1. Address: (if different from above)	Spouse Male / Female	/ /		A G F N H S
2. Address: (if different from above)	Dependent Child Male / Female	/ /		A G F N H S
3. Address: (if different from above)	Dependent Child Male / Female	/ /		A G F N H S
4. Address: (if different from above)	Dependent Child Male / Female	/ /		A G F N H S
5. Address: (if different from above)	Dependent Child Male / Female	/ /		A G F N H S
6. Address: (if different from above)	Dependent Child Male / Female	/ /		A G F N H S

** A = Adopted G = Grandchild F = Foster Child N = Natural Child H = Handicapped Child S = Stepchild – List all that apply.*

Is the employee required to cover a dependent child by court order? **Yes ____** **No ____** **IF YES, ATTACH COURT ORDER OR DIVORCE DECREE** (unless previously submitted)

Is your Spouse Employed? **Yes ____** **No ____** **If yes, where?**

Company Name Address City State Zip Code

(Continued on Back Side)

LIFE BENEFITS – Beneficiary Information

Beneficiary	Last Name	First Name	Middle Initial	Soc. Sec. Number	Relationship to You
1. Primary					
Address					
2. Secondary					
Address					

COORDINATION OF BENEFITS INFORMATION – Claims may be pended if this information is not completed

1. On the day your health coverage begins, will any family member be covered by any other health insurance or Medicare? Yes ____ No ____
   If yes, you must list coverage details below to ensure claims will not be delayed:

Dates of Coverage	**Name of Insurer or Plan**	**Names of All Family Members Covered** (Use extra page if necessary)
Policy Start: ____/____/____ End: ____/____/____		
Policy Start: ____/____/____ End: ____/____/____		
Policy Start: ____/____/____ End: ____/____/____		
Policy Start: ____/____/____ End: ____/____/____		
Policy Start: ____/____/____ End: ____/____/____		

2. Are you or your spouse covered by Medicare? Part A ____ or Part B ____ Please attach a copy of Medicare card or give effective dates.
3. Medicare eligibility due to: Age _____ Kidney failure _____ Disability ____ Name of condition(s) _____

EMPLOYEE AUTHORIZATION AND REPRESENTATION – Read this section, date and sign the application

I, the undersigned, hereby authorize any physician, or other provider or employee of Health Services, to provide the South Central Minnesota Electrical Workers Family Health Plan (the "Plan") with any information concerning my condition or treatment or any Family Dependent of mine who is covered under this Contract. Such information shall be provided upon request, whenever such information is deemed reasonably necessary by the Plan. I further authorize and request the Plan to provide my employer or my employer's designated plan administrator, with access to my medical and hospital claims submitted for payment or in fulfillment of any obligation imposed on the Plan of my employer by state of federal statutes. A photocopy of this Authorization shall be treated in the same manner as an original.

I hereby apply for Group Insurance Benefits for which I am eligible and I authorize payment of medical benefits directly to the South Central Minnesota Electrical Workers Family Health Plan's participating providers for services performed under this Plan. Furthermore, authorization is granted to deduct from my salary or wage, if necessary, any contribution required for the coverage selected.

_____
Participant Name (Please Print)

_____ _____
Participant Signature Date

A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Please return completed form to Wilson-McShane Corporation, 1330 Conway St, Suite 130, St. Paul, MN 55106