

HIOS ID# _____
 EC _____

Commercial Group Health Insurance Application/Change Form

CONFIDENTIAL

Please print clearly and complete all sections that apply. Signatures are required. Additional instructions included on Page 4.

Section 1: Employer Group & Benefit Information To be completed with your Group Administrator

Employer Name _____		Association/Chamber Name (if applicable) _____		Check Desired Action <input type="checkbox"/> Add <input type="checkbox"/> Cancel <input type="checkbox"/> Change
Group Administrator's Signature (required) _____	Date _____	Employee Number _____	Department Number _____	
Medical Information If enrolling in a Medical plan, who do you need coverage for? <input type="checkbox"/> Self Only <input type="checkbox"/> Self & Child(ren) <input type="checkbox"/> Self & Spouse, or <input type="checkbox"/> Self & Domestic Partner <input type="checkbox"/> Family _____ / _____ / _____ Medical Effective Date	Subscriber Status: <input type="checkbox"/> Actively Working <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Canceled <input type="checkbox"/> COBRA	Dental Information If enrolling in a Dental plan, who do you need coverage for? <input type="checkbox"/> Self Only <input type="checkbox"/> Self & Child(ren) <input type="checkbox"/> Self & Spouse, or <input type="checkbox"/> Self & Domestic Partner <input type="checkbox"/> Family _____ / _____ / _____ Dental Effective Date	Medical Group Number (8 digits) _____ Medical Subgroup Number (4 digits) _____ Medical Class Number (e.g. A001) _____	
Medical Plan Selection _____ _____ _____		Dental Plan Selection _____ _____ _____		

Section 2 : Subscriber's Information

Last Name _____ First Name _____ Middle Initial _____ Title (e.g., Jr, Sr, III, etc.) _____	Birthdate : _____ / _____ / _____ Gender assigned at birth : <input type="checkbox"/> Male <input type="checkbox"/> Female Gender identity (optional): <input type="checkbox"/> Transgender Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Prefer not to say <input type="checkbox"/> Non-binary <input type="checkbox"/> Preferto self-describe: _____ Social Security Number** _____ Date of Hire/Rehire: _____ / _____ / _____ Retirement Date : _____ / _____ / _____
Street Address _____ City _____ State _____ Zip Code _____ Phone _____	Subscriber's Medicare Number (if applicable) _____ Medicare Part A Effective Date _____ / _____ / _____ Medicare Part B Effective Date _____ / _____ / _____ <input type="checkbox"/> Age 65+ <input type="checkbox"/> Disability <input type="checkbox"/> End Stage Renal

Cancel Codes:

SB02-Left Employment SB05-Per Group Request SB06-Subscriber Request(voluntary) SB07-Deceased SB09-Enrolled in Error

Cancel Codes:

M001-Per Group Request M004-Enrolled in Error M008-Moved Out of Area M013-Ineligible
M002-Deceased M005-Divorced M010-Overage Dependent M014-YAO Ineligible
M003-Per Subscriber Request M007-Per Member Request(voluntary) M011-No Longer a Student M040-Mx Same Group

Spouse Domestic Partner Dependent Child Disabled Dependent Child (Separate application form required)
 Other _____

Last Name (if different) Title First Name MI Social Security Number **
Gender assigned at birth : Male Female Birthdate ____ / ____ :348dnÄKÜ "Ntdw [(Ot)?

Have you or any member of your family been enrolled in other medical or dental coverage? Yes No

If yes, what type of coverage?

Instructions for completing the Group Health Insurance Application/Change Form

Section 1: Employer Group & Benefit Information

This section should be completed with your Group Administrator. Group Administrator's signature is required. Medical and/or dental group numbers and information must be populated. Select who you need coverage for on the medical and/or dental plan(s) and indicate the subscriber's status. Next, select the medical and/or dental plan(s) you are enrolling in. All products may not be applicable to your employer group. Please check with your Group Administrator.

Section 2: Subscriber's Information

This section should be completed by the