

HCH ADMINISTRATION, INC.		ENROLLMENT / CHANGE FORM		
DRURY UNIVERSITY	Reason for completion of this form?	<input type="checkbox"/> NEW ENROLLMENT	<input type="checkbox"/> ADD DEPENDENT(S)	<input type="checkbox"/> TERMINATION
	Check applicable category(ies) → or explain:	<input type="checkbox"/> CHANGE ADDRESS	<input type="checkbox"/> DROP DEPENDENT(S)	
	Effective date of this enrollment / change:	<input type="checkbox"/> NAME CHANGE: Former name: New Name:		
Check only one: <input type="checkbox"/> HealthLink Open Access III <input type="checkbox"/> PHCS		<input type="checkbox"/> OTHER (details:)		

SECTION A: EMPLOYEE

Name (Provide Full Legal Name)		<input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Date of Marriage:	Social Security Number
Address – Street and number:		City	State	Zip Code	Telephone number ()	Email Address:
Status: <input type="checkbox"/> Active <input type="checkbox"/> COBRA <input type="checkbox"/> Retired	Job Title	Date of Hire:	Number Hours Worked/Week:	Do you have Medicare coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes -- Effective Date: Part A: Part B:		

SECTION B: SPOUSE / DOMESTIC PARTNER INFORMATION: COMPLETE ONLY IF YOU ARE APPLYING FOR DEPENDENT COVERAGE. PROVIDE LAST NAME IF DIFFERENT THAN PRIMARY BENEFICIARY'S LAST NAME.

Name (Full Legal Name)		<input type="checkbox"/> Legal Spouse <input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate	Social Security Number	Do you have Medicare coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes -- Effective Date: Part A Part B
Is spouse/Domestic Partner employed? <input type="checkbox"/> No <input type="checkbox"/> Yes—provide details →	Spouse/Domestic Partner's employer name and address:			Is your spouse/Domestic Partner covered By ANY other group plan OR Medicare? <input type="checkbox"/> No <input type="checkbox"/> Yes – please provide information below.		
Spouse's other coverage →	<u>MEDICAL</u> <input type="checkbox"/> None <input type="checkbox"/> Family <input type="checkbox"/> Enrollee Only <input type="checkbox"/> Enrollee + Spouse/DomPrtnr <input type="checkbox"/> Enrollee + Child(ren)	<u>VISION</u> <input type="checkbox"/> None <input type="checkbox"/> Family <input type="checkbox"/> Enrollee Only <input type="checkbox"/> Enrollee + Spouse/DomPrtnr <input type="checkbox"/> Enrollee + Child(ren)	Name of insurance company and phone number:	Policy or contract number	Address where claims are submitted	

SECTION C: DEPENDENT CHILDREN: COMPLETE ONLY IF YOU ARE APPLYING FOR DEPENDENT COVERAGE. PROVIDE LAST NAME IF DIFFERENT THAN PRIMARY BENEFICIARY'S LAST NAME.

DEPENDENT NAME		RELATIONSHIP	BIRTHDATE	DEPENDENT NAME		RELATIONSHIP	BIRTHDATE
PROVIDE THE FOLLOWING INFORMATION ↓	YES	NO	SOCIAL SECURITY NUMBER	PROVIDE THE FOLLOWING INFORMATION ↓	YES	NO	SOCIAL SECURITY NUMBER
	DISABLED?		NAME OF SCHOOL		DISABLED?		NAME OF SCHOOL
	RESIDE WITH YOU?		SCHOOL ADDRESS		RESIDE WITH YOU?		SCHOOL ADDRESS
	FULL-TIME STUDENT?				FULL-TIME STUDENT?		
	SCHOOL INSURANCE?				SCHOOL INSURANCE?		

DEPENDENT NAME			RELATIONSHIP	BIRTHDATE	DEPENDENT NAME			RELATIONSHIP	BIRTHDATE
PROVIDE THE FOLLOWING INFORMATION ↓	YES	NO	SOCIAL SECURITY NUMBER		PROVIDE THE FOLLOWING INFORMATION ↓	YES	NO	SOCIAL SECURITY NUMBER	
			NAME OF SCHOOL					NAME OF SCHOOL	
			SCHOOL ADDRESS					SCHOOL ADDRESS	

SECTION D: OTHER COVERAGE INFORMATION

DO YOU OR ANY OF YOUR DEPENDENTS HAVE ANY OTHER COVERAGE OTHER THAN THIS PLAN OR THE COVERAGE DESCRIBED IN SECTION B ABOVE? <input type="checkbox"/> No <input type="checkbox"/> Yes—provide details →	Names of dependent(s) with other coverage:			
Name of Group / Policyholder	Name of Insured	His/Her ID numbers	Name of Insurance Company	Address for claims submission

SECTION E: PLEASE MAKE YOUR COVERAGE / BENEFIT ELECTIONS BELOW (COMPLETE ONLY BENEFITS FOR WHICH YOU ARE ELIGIBLE)

MEDICAL/VISION select only one →

Enrollee Only
 Enrollee + Spouse/DomPrtnr
 Enrollee + Child(ren)
 Family
 Decline

IMPORTANT NOTICE:

1. If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

2. This plan contains a pre-existing conditions limitation. You have the right to demonstrate creditable coverage or existence of waiting periods to reduce or eliminate the applicable exclusionary period. You may do so by providing a certificate(s) of creditable coverage ("COCC") from prior coverages. You have the right to request COCCs from prior plan, carriers or payors and the Plan Administrator or HCH Administration, Inc. will provide assistance in obtaining COCCs if necessary.

I/We hereby request the amounts(s) and forms of coverage for which I am or may become eligible. I hereby authorize my employer to deduct the required contributions, if any, from my earnings. Additionally, I/we certify that the above information is true and correct. I/we hereby authorize all providers of healthcare services rendering care to me or any of my covered dependents to furnish the plan administrator or its designee or HCH Administration, Inc. with full information regarding treatment rendered including copies of the records. I/we also authorize any union, trust fund, employer or insurance carrier to furnish the plan administrator, its designee or HCH Administration, Inc. with information regarding benefits to which I/we may be entitled. If I declined to participate for myself or any of my eligible dependents, I understand that coverage, as a late entrant may not be available. I understand that if I decline coverage under this plan due to having other healthcare coverage and I later lose that coverage, I may be able to enroll myself and my eligible dependents provided I request enrollment within 30 days after my other coverage ends. If I gain a new dependent as a result of marriage, birth adoption or placement for adoption, I may be able to enroll my eligible dependent(s) and myself provided I request enrollment within 30 days of that event. I understand that the listing of my spouse and children on this form does not automatically qualify them as eligible dependents under the plan and that it is my responsibility to verify their eligibility for benefits under the plan, including but not limited to initial eligibility, continued eligibility based on student status or disabled status. This authorization shall remain in effect until I sign a new enrollment/change form. I understand that if I receive treatment without following precertification procedures (if applicable), I may be responsible for paying a larger portion of my medical expenses than I would have paid had I followed plan requirements. A copy of this authorization shall be valid as the original.

Date	Employee Signature	Spouse Signature (required if coverage election affects spouse)
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