HealthSCOPE BENEFITS

TO BE COMPLETED BY EMPLOYER

EFFECTIVE DATE: _____ TERM DATE: _____
REASON FOR ENROLLMENT: ☐ New Hire ☐ Open Enrollment ☐ Other _____
CHANGE: ☐ Add ☐ Drop Specify: _____

EMPLOYEE STATUS: ☐ Active ☐ Retired ☐ COBRA

ENROLLMENT APPLICATION

(PLEASE PRINT)

EMPLOYEE NAME	FIRST NAME	M.I.	SOCIAL SECURITY NO.	BIRTHDATE / /	SEX ☐ MALE ☐ FEMALE

STREET ADDRESS	CITY	STATE	ZIP CODE	COUNTY

HOME PHONE	WORK PHONE	MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

DATE OF EMPLOYMENT / /	EMPLOYEE CLASSIFICATION ☐ ACTIVE ☐ COBRA ☐ RETIREE	TYPE OF COVERAGE ☐ Single ☐ Single + Spouse ☐ Single + Children ☐ Family

DEPENDENT INFORMATION

COMPLETE THE FOLLOWING INFORMATION FOR EACH DEPENDENT TO BE COVERED BY THE PLAN

(Please add additional sheet if necessary)

LAST NAME	FIRST NAME	M.I.	RELATIONSHIP	SEX	BIRTHDATE	SOCIAL SECURITY #
			*SPOUSE			

*In order to enroll your spouse/ on Drury's health plan, please complete the Spouse Other Coverage Information Form.

COORDINATION OF BENEFITS INFORMATION

Is there any other health insurance in force for you or any family member? ☐ YES (answer the following) ☐ NO

NAME OF POLICYHOLDER	POLICY NO./SOCIAL SECURITY #	BIRTHDATE / /

INSURANCE COMPANY NAME AND ADDRESS	EMPLOYER THROUGH WHICH POLICY IS HELD (if any)	EFFECTIVE DATE OF COVERAGE / /

TYPE OF POLICY: ☐ HOSPITALIZATION ☐ MAJOR MEDICAL ☐ VISION ☐ DENTAL ☐ OTHER _____
IF MEDICARE, CHECK ONE: ☐ MEDICARE A (hospital) ☐ MEDICARE B (medical) ☐ BOTH A & B

TYPE OF COVERAGE: ☐ EMPLOYEE ☐ EMPLOYEE + SPOUSE ☐ EMPLOYEE + CHILD(REN) ☐ FAMILY
If Family, list individuals covered:

WAIVER

I have read and understand the material explaining the available coverage options and have elected NOT to enroll.

EMPLOYEE SIGNATURE: _____ DATE: _____

I have read and understand the material provided explaining the coverage options and have elected to enroll in this program. I understand the members covered under my contract should adhere to the provisions of the program.

To all persons or institutions licensed to provide health care, pharmacies, educational institutions, and other agencies (including insurance companies): You are authorized to permit HealthSCOPE Benefits or its representatives to obtain or view a copy of my medical, health care, or school records on the above named patient(s).

HealthSCOPE Benefits is authorized to use, release, disclose, or discuss in person or telephonically the information to the extent necessary to determine the value or amount payable on any claim, to ensure proper and correct policy / contract administration, and as needed for medical case management.

This authorization, or a photographic copy thereof, is valid for the term of coverage of the policy or contract under which a claim has been submitted, I understand that a copy of this authorization is available to me upon request.

I hereby represent that all information furnished is true and complete to the best of my knowledge.

EMPLOYEE SIGNATURE: _____ DATE: _____

NOTE: If the above information changes, please contact your employer to update your information.

Revised 11/1/15