

ENROLLMENT FORM

EMPLOYER NAME		ORIGINAL ENROLLMENT DATE		PLAN #	
APPLICANT NAME (FIRST, M.I. LAST)				SOCIAL SECURITY #	
APPLICANT ADDRESS	STREET	CITY	STATE	ZIP	
PHONE #	DEPT CODE	EMPLOYMENT DATE	MARITAL STATUS S M D W	SEX M F	DATE OF BIRTH
I HEREBY APPLY FOR MEDICAL COVERAGE ON: HIGH DEDUCTIBLE PLAN CORE DEDUCTIBLE PLAN		<input type="checkbox"/> EMPLOYEE ONLY		<input type="checkbox"/> EMPLOYEE & SPOUSE	
		<input type="checkbox"/> EMPLOYEE & CHILDREN		<input type="checkbox"/> FAMILY	

COMPLETE THE FOLLOWING FOR ELIGIBLE DEPENDENTS

FULL NAME (FIRST, M.I., LAST)	ORIGINAL EFFECTIVE DATE	D.O.B MO. DAY.YR	SEX	RELATIONSHIP TO EMPLOYEE	FULL TIME STUDENT

IF CHILD IS OVER 18, HE/SHE IS A FULL TIME STUDENT AT:
 NAME OF COLLEGE _____
 ADDRESS OF COLLEGE _____
 TELEPHONE # OF COLLEGE _____

DO ALL COVERED DEPENDENTS LIVE WITH EMPLOYEE? YES NO
 IF "NO", LIST DEPENDENTS, RESIDING CITY, RESIDING STATE AND EXPLAIN: _____

ARE YOU OR YOUR DEPENDENTS COVERED BY ANY OTHER GROUP HEALTH INSURANCE PLAN? (CIRCLE ONE)

	EMPLOYEE YES NO	SPOUSE YES NO	DEPENDENT CHILDREN YES NO
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REMARKS: IF YOU INDICATED "YES" TO THE ABOVE, PLEASE PROVIDE THE FOLLOWING INFORMATION REGARDING THE OTHER GROUP HEALTH INSURANCE COVERAGE.

EMPLOYER OR GROUP NAME		GROUP #	EFFECTIVE DATE
ID #	POLICYHOLDER	POLICYHOLDER DOB	RELATIONSHIP TO APPLICANT
NAME & ADDRESS OF INSURANCE COMPANY			TELEPHONE #

EMPLOYEE AUTHORIZATION

I hereby authorize my physician(s) and any hospital, clinic, medical provider, or insurance company now in possession of any of my individually identifiable health information relating to the enrollment of benefits described above to disclose said information as is necessary to process this enrollment to NovaSys Health and/or its contracted vendors and/or the Medical Information Bureau. This authorization shall expire upon the termination of my enrollment in the benefits applied for herein.

I understand that I may revoke this authorization at any time by notifying NovaSys in writing, except to the extent that: (a) action has been taken in reliance on this authorization; or (b) if this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or ability to obtain treatment, except as follows: (a) If the purpose of this authorization is for NovaSys to determine eligibility before enrollment, the requested use or disclosure is not for psychotherapy notes, and I refuse to sign this authorization, NovaSys reserves the right to deny enrollment or eligibility for benefits. (b) If the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this authorization, NovaSys reserves the right to deny that health care.

I understand the information I have authorized to be used or disclosed may have to be redisclosed and no longer protected by federal privacy regulations.

Employee Signature: _____ Date Signed: _____

WAIVER OF MEDICAL COVERAGE:

This is to acknowledge the available coverages have been explained to me by my employer. I have been given the opportunity to apply for the available coverages and have elected not to enroll myself and/or dependents, if any, for the coverage(s) selected above.

Employee Signature: _____ Date Signed: _____

NOTICE: 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 the 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 a 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.

If you have any questions, please call 877-362-9003
 Please make a copy for your records if needed.