



LOCAL GOVERNMENT HEALTH PLAN Member Enrollment Form

Unit Name: _____ Member Name: _____

MEMBER BIOGRAPHICAL INFORMATION (Please Print or Type)

Member SSN: _____ Temporary SSN: Yes No Org. Proc. Code: _____ Eff. Date of Add: _____

Name (As it appears on SS Card)

Last: _____ First: _____ Middle: _____

Phone: _____ E-mail: _____

Marital Status: Single Married Birthdate: _____ Sex: Male Female

Medicare Status: (check one)

- | | |
|---|--|
| <input type="checkbox"/> 1. Non Medicare | If Medicare is 2, 4, 5 complete the following: |
| <input type="checkbox"/> 2. Medicare Eligible 65+ | Part A (begin date) _____ |
| <input type="checkbox"/> 3. Medicare Ineligible 65+ | Part B (begin date) _____ |
| <input type="checkbox"/> 4. Medicare Disability | Part D (begin date) _____ |
| <input type="checkbox"/> 5. End Stage Renal | Part A Free <input type="checkbox"/> Yes <input type="checkbox"/> No |

If the member has a power of attorney, legal guardian or trustee, please complete the Other Addressee Information if the address is different than members.

Member Residential Address

Other Addressee Information

City/State: _____

Name: _____

ZIP Code: _____ County: _____

City/State: _____

Send Mail to this Address? Yes No

ZIP Code: _____ County: _____

Addressee SSN: _____

Relationship: _____

Date of Relationship: _____

Send Mail to this Address? Yes No

MEMBER GROUP

Hire Date: _____ Type Enrollee: _____ Part Time Full Time

SURVIVORS ONLY

SSN of deceased Member: _____ Relationship to Deceased Member: Spouse Child



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Unit Name: _____ Member Name: _____

Member SSN: _____

UNIT INFORMATION

Work County Code: _____

MEMBER HEALTH PLAN

Carrier Code: _____ NPI# (if applicable): _____ Medical Group/IPA# (if applicable): _____

I elect to waive coverage. Member Initials: _____

I authorize prevailing premiums (if any) to be deducted from my pay or annuity for the coverage I have selected. This authorization is to remain in effect until I provide written notice to the contrary. The statement and answers contained in this application are complete and true. I agree to abide by all appropriate rules and furnish any additional information if requested.

My signature confirms that I understand all above options selected. At all times this form must be signed by the member.

Required Member Signature: _____

Date: _____

I have reviewed and explained all options available to the above member.

Health Plan Representative Signature: _____

Date: _____

Health Plan Representative Phone Number: _____