FOR INTERNAL USE ONLY

HIOS ID# _____

EC_____

Commercial Group Health Insurance Application/Change Form

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)

_____ _____ _____

Group Administrator's Signature (required) Date

Employee Number

Department Number

Medical Information

_____

Medical Group Number (8 digits)

_____

Medical Subgroup Number (4 digits)

_____

Medical Class Number (e.g. A001)

If enrolling in a Medical plan, who do you need coverage for?

- Self Only
- Self & Child(ren)
- Self & Spouse, or
- Self & Domestic Partner
- Family

_____ /_____ /_____

Medical Effective Date

Medical Plan Selection

Birthdate : _____ /_____ /_____

Gender assigned at birth :

OŠMale

OŠFemale

Social Security Number** _____

Date of Hire/Rehire: _____ /_____ /_____

Retirement Date: _____ /_____ /_____

Street Address

_____ _____

City State

_____

Subscriber's Medicare Number (if applicable)

_____ /_____ /_____ _____ /_____ /_____

Medicare Part A Effective Date Medicare Part B Effective Date

_____ _____

Zip Code Phone

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

OŠSpouse OŠDomestic Partner OŠDependent Child OŠDisabled Dependent Child(Separate application form required)
OŠOther_____

_____ _____ _____ _____
Last Name (if different) Title First Name MI Social Security Number **

Gender assigned at birth : OŠMale OŠFemale Birthdate _____ /_____ /_____
Gender identity (optional): OŠTransgender Male OŠTransgender Female •Non-binary •Prefer not to say •Prefer to self-describe: _____

Is dependent a full-time student over age 19? OŠYesOŠNo Married? OŠYes OŠNo Expected Graduation Date: _____ /_____ /_____
If yes, please provide name of college/university _____ Will dependent further education after graduation? OŠYesOŠNo

Medicare Eligible OŠYesOŠNo If yes, indicate reason OŠAge 65+ OŠDisability OŠEnd Stage Renal

_____ Part A Effective Date: ___ /___ /____ Part B Effective Date: ___ /___ /____
Medicare Number (if applicable)

OŠDependent Child OŠDisabled Dependent Child(Separate application form required) OŠOther_____

_____ _____ _____ _____
Last Name (if different) Title First Name MI Social Security Number **

Gender assigned at birth : OŠMale OŠFemale Birthdate _____ /_____ /_____

Married

Have you or any member of your family been enrolled in other medical or dental coverage? OŠYes OŠNo

If yes, what type of coverage? OŠMedical OŠDental

What is the effective date of the other coverage? OŠMedical: ____ / ____ / _____ OŠDental____ / ____ / _____

What is the name of the other carrier? _ _____

Are you keeping the coverage? OŠYes OŠNo

If noQTf -0.0526007 Tw 1.01 Tw n8BDC -0. Tc 0 Tw/ 1.383/0 Td ( )Tj -0.0 OŠ Tw 1.01/Tw nnB01 Tw i3yTj EMC /P 2.874 1

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