nova SM
An Independent Health company

HEALTHCARE ENROLLMENT FORM

Employer Information (employer use only)	
Group Name: Niagara County	Group #:
Date of Hire:	Effective Date:
Department (if applicable):	HRA Amount:
Status: Active ❑ Retired ❑	Medicare
COBRA ❑ COBRA Effective Date:	
Employer Initials:	Date:

For New Enrollments/Please check one:	For Changes/Please check all that apply:
❑OPEN ENROLLMENT ❑NEWLY ELIGIBLE/REASON _____ ❑NEW HIRE/DATE OF HIRE ___/___/___	❑PLAN CHANGE ❑ADD DEPENDENT/QUALIFYING EVENT (birth, marriage, etc.) _____ ❑NAME CHANGE ❑ADDRESS CHANGE ❑REMOVE DEPENDENT

❑ ***I do not wish to elect health coverage at this time***

PLEASE PRINT AND RETURN TO YOUR EMPLOYER UPON COMPLETION.

APPLICANT'S LAST NAME	FIRST NAME	MI	GENDER	EMPLOYEE STATUS	SOCIAL SECURITY NUMBER
			❑MALE ❑FEMALE	❑ACTIVE ❑RETIREE DATE ___/___/___	

ADDRESS (NUMBER, STREET, APARTMENT)	DATE OF BIRTH

CITY	COUNTY	STATE	ZIP + 4	CONTACT INFORMATION
				HOME: ( ) - CELL: ( ) - WORK: ( ) - E-mail:

COVERAGE INFORMATION

MEDICAL & RX: ❑ Single ❑ Family ❑ Other (please specify) _____

PLAN SELECTION (Please indicate on line below.)

Plan name: _____

MEMBER INFORMATION

LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP
SPOUSE					❑Husband ❑Wife
CHILD					❑Daughter ❑Son
CHILD					❑Daughter ❑Son
CHILD					❑Daughter ❑Son
CHILD					❑Daughter ❑Son

While enrolled in your employer's group health plan, will you or your dependent (s) be covered by any of the following: If additional space is required, please attach a separate sheet.

CHECK YES or NO for MEDICARE ❑YES (please list all covered members) ❑NO	LAST NAME FIRST MI	ID NO. _____ Part A Effective Date _____ Part B Effective Date _____
OTHER HEALTH COVERAGE ❑YES (please list all covered members) ❑NO *including no fault and/or workers' compensation (in the event of an injury)	LAST NAME OF POLICY HOLDER FIRST MI	INSURANCE NAME PHONE NO.

CERTIFICATION & CONSENT

I certify that the information given on this application is current, true and correct to the best of my knowledge and I have read and agree to this statement. This application cannot be processed if birth date(s) and Social Security Number(s) are not completed. I understand that any person who knowingly and with intent to defraud, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto or commits a fraudulent act which is a crime, may be subject to the maximum penalties allowed by law and adverse action by the employer.

Subscriber's Signature	Date