FOR INTERNAL USE ONLY

HIOS ID# _____

EC_____

CONFIDENTIAL

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

Check Desired Action
† Add † Cancel † Change

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

Subscriber Status:
- OŠ Actively Working
- OŠ Retired
- OŠ Disabled
- OŠ Canceled
- OŠ COBRA

Dental Information

_____
Dental Group Number

_____
Dental Subgroup Number

_____
Dental Class

If enrolling in a Dental plan, who do you need coverage for?
- Self Only
- Self & Child(ren)
- Self & Spouse, or
- Self & Domestic Partner
- Family

____ /_____ /_____
Dental Effective Date]

Medical Plan Selection

Dental Plan Selection

Section 2 : Subscriber's Information

_____
Last Name

_____
First Name

_____ _____
Middle Initial Title (e.g., Jr, Sr, III, etc.)

_____
Street Address

_____ _____
City State

_____ _____
Zip Code Phone

Birthdate : _____ /_____ /_____

Gender assigned at birth :
- OŠ Male
- OŠ Female

Gender identity (optional):
- OŠ Transgender Male
- OŠ Transgender Female
- OŠ Prefer to self-describe: _____
- OŠ Prefer not to say
- OŠ Non-binary

Social Security Number** _____

Date of Hire/Rehire: _____ /_____ /_____

Retirement Date : _____ /_____ /_____

- OŠ Age 65+
- OŠ Disability
- OŠ End Stage Renal

_____
Subscriber's Medicare Number (if applicable)

_____ /_____ /_____
Medicare Part A Effective Date

_____ /_____ /_____
Medicare Part B Effective Date

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 _____ /_____ :348dnÀKÜ "Ntdw [(Ot)?

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

If yes, what typ1 Tf -0.001 nTw 10.02 0 0 10.02 489 546.48 Tm [((,) ( )0.-1.9 (v Q q 27.1)5)]TJ ET QTJ ET Q q 27.12 T 10.02T 10.0

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 Information This section should be completed by the