

Preferred Health Systems Insurance Company ("PHSIC") High Deductible Health Plan Enrollment Form

- Premium Plan
 Base Plan

PLEASE TYPE OR PRINT

SSN		Employee's Legal Last Name			Legal First Name			MI	
Street Address				City			State	Zip Code	
Home Phone		Work Phone	Birth Date	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Common Law Married	Your Employer/Company Name		Group Number	

PLEASE LIST SPOUSE YOU WISH TO ENROLL IN MEDICAL COVERAGE (if common law married attach affidavit)

Last Name		First Name		MI	Birth Date	Sex	SSN	
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PLEASE LIST CHILDREN AND OTHER ELIGIBLE DEPENDENTS YOU WISH TO ENROLL IN MEDICAL COVERAGE

Last Name	First Name	MI (List address if different)	Birth Date	Sex	SSN	Relationship	Full Time College Student (Please attach schedule) <input type="checkbox"/> Yes <input type="checkbox"/> No

Are you or any person listed above totally disabled? Yes No If so, who is disabled? _____

After you are enrolled in PHSIC, will you or any person above be covered by other health insurance? Yes No If yes, what insurance _____

Insurance Company phone number _____ Policyholder's Name _____ Policyholder's Date of Birth _____ Policyholder's ID# _____

Names of those covered _____

When selecting a qualified high deductible health plan, I understand that I am required to establish a federally qualified health savings account on the effective date of the policy. _____ (please initial) I hereby apply for enrollment for the individual(s) listed above. I authorize my employer to deduct from my earnings my contribution to the premium. I hereby consent to the release of information or medical records concerning services or supplies provided to me or my covered dependents by any health care provider, allied health professional, hospital or medical care institution to PHSIC or its designee for the purpose of quality or utilization review or payment of a claim. A copy of this consent is available upon request. The consent is valid for the duration of the coverage. I represent that the information I have provided on this form is correct and that I do hereby agree to the terms and conditions set out in the plan.

Employee's Signature _____ Date _____

MUST BE COMPLETED BY EMPLOYER

Date of Employment: _____ Please check one of the following: New Hire _____ Open Enrollment _____ Loss of other group coverage _____ Date of loss _____ Other _____ Please list reason such as: change in family status, PT to FT, Loss of other coverage _____ Date of Qualifying Event _____

Effective Date of Coverage _____ Employer Signature _____ Title _____ Date _____

Preferred Health Systems Insurance Company • P.O. Box 49288, Wichita, KS 67201-9288 • 316-609-2390 • Outside Sedgwick Co. 1-800-660-8114 • Fax 316-609-2327

White: Preferred Health Systems Insurance Company Copy Yellow: Employer Copy Pink: Employee Copy/Temporary Identification Card

an affiliated company of  **Preferred Health Systems**