

WESTERN MICHIGAN HEALTH INSURANCE POOL (WMHIP)

Name of Employer/Plan Sponsor: WMHIP – Jenison Public Schools	Group # 71565	Plan Choice: _____ \$1,500/\$3,000 100% HSA PAK A \$40 DRUG CARD _____ \$1,500/\$3,000 100% HSA , PAK C \$80 DRUG CARD
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Check One: <input type="checkbox"/> Initial <input type="checkbox"/> Change <input type="checkbox"/> Termination <input type="checkbox"/> Reinstatement			
Reason for Change (check all that apply): _____ Initial Eligibility Following Hire _____ Open Enrollment _____ Status Change: _____ _____ Other: _____	Occupation: _____	Date of Hire: _____ Hours Worked Weekly: _____	Effective Date of Coverage or Change: _____

Employee Information

Employee Name (last, first, middle initial): _____	<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth: _____	Social Security Number: _____	
Street Address: _____	Telephone (including area code): Work: _____ Home: _____			
City: _____	State: _____	ZIP Code: _____		
Do you have other insurance through your spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Spouse's Employer: _____	Name of Insurance Carrier: _____ <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Plan Number: _____	Type of Coverage: <input type="checkbox"/> Single <input type="checkbox"/> Family
Does any proposed insured have other medical coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Insurance Carrier: _____	Plan Number: _____	Effective Date: _____ End Date: _____	
Are you or any of your dependents eligible for Medicare benefits? <input type="checkbox"/> Yes Name: _____ <input type="checkbox"/> No	Is any proposed insured currently covered under COBRA? <input type="checkbox"/> Yes Effective Date: _____ <input type="checkbox"/> No			
If coverage for a child or children is mandated by divorce decree or paternity order, please submit a copy of the decree or order with this form.				
Who is responsible for coverage of child(ren) listed? <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Both <input type="checkbox"/> Other				
Who has physical custody? <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other				

Dependent's Name	Relationship to Child	Birth Date	Social Security Number	Sex	Termination Date
Spouse:				<input type="checkbox"/> Female <input type="checkbox"/> Male	
Child:	<input type="checkbox"/> Natural <input type="checkbox"/> Step			<input type="checkbox"/> Female <input type="checkbox"/> Male	
Child:	<input type="checkbox"/> Natural <input type="checkbox"/> Step			<input type="checkbox"/> Female <input type="checkbox"/> Male	
Child:	<input type="checkbox"/> Natural <input type="checkbox"/> Step			<input type="checkbox"/> Female <input type="checkbox"/> Male	
Child:	<input type="checkbox"/> Natural <input type="checkbox"/> Step			<input type="checkbox"/> Female <input type="checkbox"/> Male	

EMPLOYEE CERTIFICATION AND SIGNATURE

- To the best of my knowledge and belief, the information I have provided on this form is correct. I hereby certify that the dependents listed above are my dependents within the definition contained in the group Plan of my employer. I agree to notify the Plan Administrator if and when there is a change in any dependent's status.
- The current benefits have been explained to me thoroughly. I hereby request coverage as outlined above under the Plan offered by my employer for which I am or may become eligible, and I authorize my employer to deduct any required contribution from my earnings. I reserve the right to revoke this authorization at any time upon written notice.
- I understand that any person who knowingly and with intent to defraud submits an application or files a claim containing any materially false or misleading information commits a fraudulent act, which is a crime.**
- I understand that in the event of any discrepancy between this enrollment form and any policy in which I am enrolling, the terms of the policy shall apply.
- I understand my coverage begins on the effective date assigned by the Administrator, provided I have met all eligibility requirements.

EMPLOYEE SIGNATURE: _____

DATE: _____