

PLEASE USE THIS INSTRUCTION PAGE AS A GUIDE IN COMPLETING THE GROUP ENROLLMENT/CHANGE FORM

Sections 1 and 2 must be fully completed for enrollment processing



**Group Enrollment/Change Form**

**PO Box 269001  
Plano, TX 75026-9001**

<b>1. Employee Information (Please type or print in ink)</b>						
<input checked="" type="checkbox"/> New <input type="checkbox"/> Change	Employee (First Name, MI, Last Name) <i>John J. Newform</i>			Social Security #	<input type="checkbox"/> Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Divorced	
Street Address <i>123 MAIN STREET</i>	City, State <i>AWYTOWN WI</i>	Zip Code <i>99999</i>	County <i>ANY</i>	Home Phone (999) <i>555-1234</i>	E-mail address <i>john@ppplusic.com</i>	
<b>2. Family Information and Primary Care Physician (PCP) Selection</b>						
Full Name of Members to be Covered	Relationship	Gender (M/F)	Social Security #	Birthdate	PCP: First Name/Last Name/Provider # (call (608) 282-8900 or (800) 545-5015 for help selecting a PCP)	Enrollment Dept. Use Only
Employee <i>John J. Newform</i>	Self	M	<i>999-99-9999</i>	<i>1/2/57</i>	<i>ADAM DOCTOR 222-3334</i>	<i>YES</i>
Spouse <i>AMY E. Newform</i>	Spouse	F	<i>111-11-1111</i>	<i>2/3/58</i>	<i>ADAM DOCTOR 222-3334</i>	<i>YES</i>
Dependent <i>SOPHIE B. Newform</i>	Daughter	F	<i>555-55-5555</i>	<i>3/4/99</i>	<i>ADAM DOCTOR 222-3334</i>	<i>YES</i>
Dependent						
Dependent						
If dependents listed above reside at a different address, please list their name(s) and address(es)						
<b>3. Medical Plan Option (Please select your plan type. Consult your employer if multiple plans are offered.)</b>						
HMO <input checked="" type="checkbox"/> Copay <i>20</i> <input type="checkbox"/> HealthShare <input type="checkbox"/> Custom <input type="checkbox"/> Regular <input type="checkbox"/> Tiered Copay <input type="checkbox"/> HSA-Qualified <input type="checkbox"/> PPO <input type="checkbox"/> Copay <input type="checkbox"/> Tiered Copay <input type="checkbox"/> HSA-Qualified <input type="checkbox"/>						
POS <input type="checkbox"/> Copay <input type="checkbox"/> Custom <input type="checkbox"/> Regular <input type="checkbox"/> Tiered Copay <input type="checkbox"/> HSA-Qualified <input type="checkbox"/>						
<b>4. Other Health Insurance Information</b>						
Do you or any of your dependents receive Workers Compensation Benefits? <input type="checkbox"/> YES <input type="checkbox"/> No If Yes, please indicate member's name:						
Are you or any of your dependents currently disabled? <input type="checkbox"/> YES <input type="checkbox"/> No If Yes, please indicate member's name:						
When enrolled with Physicians Plus, will you or anyone listed on this application be covered by other health or prescription insurance? <input type="checkbox"/> YES <input type="checkbox"/> No (If Yes, complete below)						
Insurance Company				Address		
Phone		Name of Insured		Dependents Covered		
Policy Effective Date		Group/Policy Number			Employer Name	
List anyone named above who is eligible for Medicare		Reason <input type="checkbox"/> Over 65 <input type="checkbox"/> Kidney Failure <input type="checkbox"/> Disability		Specify Medicare Part A, B, C or D and Effective Date		Medicare Number
<b>5. Authorization Signature to Obtain or Release Medical Information</b>						
On behalf of myself and my eligible dependents, I hereby agree to the terms and conditions of enrollment and to the Authorization to Obtain or Release Medical Information which appears above and on the reverse side of this application.						
Employee Signature: <i>John J. Newform</i>		Date <i>9/13/08</i>		Spouse/Partner Signature (if applicable) <i>Amy Newform</i>		Date <i>9/13/08</i>
<b>6. For Employer Use Only</b>						
Date of Hire	Effective Date	Is the employee currently working? <input type="checkbox"/> YES <input type="checkbox"/> NO		Hours Worked per week	Group/Division #	
<input type="checkbox"/> New Hire <input type="checkbox"/> New Group <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> Family Status Change			Describe Special Enrollment & attach documentation:		Date of Special Enrollment	Effective Date of Change
<input type="checkbox"/> Late Entrant <input type="checkbox"/> Annual Multi Carrier <input type="checkbox"/> Cancel All Coverage <input type="checkbox"/> Other			Reason for Change: <input type="checkbox"/> Elect Continuation/COBRA <input type="checkbox"/> Add Dependents listed above <input type="checkbox"/> Delete dependents listed above <input type="checkbox"/> Other			
Name of Employer		E-mail Address		Phone	Approved by	Date

This section must be completed if any other medical insurance is in effect.

Sign and date here

Section 6 will be completed by your employer

If PCP Selection and current patient information are not completed, all claims will be denied and ID cards will not be sent. If you need assistance selecting a PCP, please contact Member Service at (800) 545-5015 or ppinfo@ppplusic.com.

Provider Name  
Schell, Debra, MD  
P+ Provider ID 1021251  
Provider Number

**White & Yellow Copies:** Physicians Plus **Pink Copy:** Applicant

P+3711-0804

**Employee Note:** If you are adding a dependent due to adoption or change in custody, a copy of court papers is required. Please review the AUTHORIZATION ACCEPTANCE/AGREEMENT on the reverse side of this page.

## ACCEPTANCE/AGREEMENT Group Applicant

By signing this application, I understand and agree that: a) All statements and answers are complete and true to the best of my knowledge and belief; b) The insurance I hereby apply for will be effective only when Physicians Plus Insurance Corporation (Physicians Plus) approves this application, and evidence of such approval will be issuance of the Medical Certificate in accordance with the group master policy; c) I hereby designate the group policyholder as my remitting agent; and d) I authorize Social Security Number use for identification purposes.

I understand that my employer, not Physicians Plus, represents me, my spouse and my legal dependents and my employer acts as my/our sole agent for any and all purposes. I understand that any insurance agent, broker or my employer cannot modify, waive or change in any way this application, any requirement imposed by Physicians Plus, bind coverage or guarantee approval of this application. I further understand and agree that Physicians Plus, its directors, officers, employees and agents shall not be liable for any injury, damage or expense (including attorneys' fees), I, and/or my spouse and/or any of my dependent(s) suffer as a result of any improper advice, action or omission on the part of any health care provider.

### **Authorization to Obtain and Release Medical Information**

By my (our) signature on this application, I (we) authorize: (1) any physician, medical practitioner, hospital, clinic, medically-related facility or other institution who provided treatment or service to me, my spouse and/or my legal dependent(s) listed on the front of this form (to the extent permitted by law) at any time, or their agent(s) (including billing service), having medical information that includes, but is not limited to, identification, medical history, diagnosis, prognosis, consultations, advice, treatments, services, dates of treatments and/or services, test results (excluding any HIV antibody test or genetic test results, but including x-rays) or summary reports, without limitation to period of treatment, diagnostic or therapeutic information, history or type of injury or illness (including pregnancy) and treatment or service, if any, for mental or nervous conditions (excluding psychotherapy notes as defined by law), alcohol or drug abuse, including all programs in which the patient has been enrolled as an alcohol or drug abuse patient; and (2) any insurance or reinsuring company, service or prepaid benefit plan, plan administrator, consumer reporting agency, employer or personal or business associate having non-medical information about me, my spouse and/or my minor child(ren); to disclose to Physicians Plus or their representative(s) (including claims and underwriting departments) all such information (including photographic copies thereof).

I understand that said information will be used by Physicians Plus to determine eligibility for coverage, evaluate and audit claims and determine availability of benefits under the Physicians Plus group health insurance policy, benefit plan or other contract, if issued by Physicians Plus to my employer. I agree that Physicians Plus may release said information to its representative(s) or other person(s) or organization(s) performing business or legal services in connection with my claim(s) or the claim(s) of my spouse and/or my dependent(s) or as may be otherwise permitted by law or as I may further authorize from time to time.

I further authorize Physicians Plus at its option to furnish and deliver to my employer and/or group policyholder or its representative(s) in accordance with the Physicians Plus group health insurance policy, non-identifying personal health information related to the cost of treatments and/or services, payment(s) made for treatments and/or services, dates of said payment(s), and recipients of said payment(s). I understand that the purpose and/or need for such disclosure is for said person(s) to promote health and wellness within the group policy, evaluation of policy premium fluctuation, utilization management and/or the transfer of claims administration.

I understand that I will receive a copy of this authorization. I understand that I have the right to inspect or copy the personal health information to be used or disclosed by Physicians Plus. I understand that this authorization is revocable upon advance written notice given to Physicians Plus at its office in Madison, Wisconsin, except that any information released in reliance thereon and prior to such revocation cannot be retrieved and Physicians Plus and its directors, officers, employees and agents shall not be held responsible or liable for such release.

I understand that Physicians Plus may not condition treatment, payment, enrollment or eligibility for benefits on the provision of this authorization. I also understand that I may refuse to sign this authorization; however, in doing so, Physicians Plus may condition payment of claims and services as permitted by law. I understand that this authorization will remain valid for up to thirty months from the date I or my legal representative execute this authorization or, if longer and permitted by law, for so long as the policy is in force under Physicians Plus. I further understand that a photographic copy of this authorization is as valid as the original.

I understand that I may obtain a detailed description of Physicians Plus's Notice of Privacy Practices from the Physicians Plus Web Site or I may obtain a copy by contacting Physicians Plus Insurance Corporation directly.

Signature of this Agreement does not authorize the use or disclosure of information which is prohibited under Section 631.90 Wisconsin Statutes as it relates to provisions concerning HIV or the use or disclosure of information which is prohibited under Section 631.89 Wisconsin Statutes as it relates to genetic tests.

## 1. Employee Information (Please type or print in ink)

<input type="checkbox"/> New <input type="checkbox"/> Change	Employee (First Name, MI, Last Name)	Social Security #	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced		
Street Address	City, State	Zip Code	County	Home Phone ( ) Work Phone ( )	E-mail address

## 2. Family Information and Primary Care Physician (PCP) Selection

Full Name of Members to be Covered	Relationship	Gender (M/F)	Social Security #	Birthdate	PCP: First Name/Last Name/Provider # (call (608) 282-8900 or (800) 545-5015 for help selecting a PCP)	Enrollment Dept. Use Only	Are you a current patient of this PCP?
Employee	Self						
Spouse	Spouse						
Dependent							
Dependent							
Dependent							

If dependents listed above reside at a different address, please list their name(s) and address(es)

## 3. Medical Plan Option (Please select your plan type. Consult your employer if multiple plans are offered.)

**HMO**  Copay \_\_\_\_  HealthShare \_\_\_\_  Custom  Regular  Tiered Copay \_\_\_\_  HSA-Qualified \_\_\_\_ **PPO**  Copay \_\_\_\_  Tiered Copay \_\_\_\_  HSA-Qualified \_\_\_\_  
**POS**  Copay \_\_\_\_  Custom  Regular  Tiered Copay \_\_\_\_  HSA-Qualified \_\_\_\_

## 4. Other Health Insurance Information

Do you or any of your dependents receive Workers Compensation Benefits?  YES  No If Yes, please indicate member's name:

Are you or any of your dependents are currently disabled?  YES  No If Yes, please indicate member's name:

When enrolled with Physicians Plus, will you or anyone listed on this application be covered by other health or prescription insurance?  YES  No (If Yes, complete below)

Insurance Company	Address	
Phone	Name of Insured	Dependents Covered
Policy Effective Date	Group/Policy Number	Employer Name
List anyone named above who is eligible for Medicare	<b>Reason</b> <input type="checkbox"/> Over 65 <input type="checkbox"/> Kidney Failure <input type="checkbox"/> Disability	Specify Medicare Part A, B, C or D and Effective Date
		Medicare Number

## 5. Authorization Signature to Obtain or Release Medical Information

On behalf of myself and my eligible dependents, I hereby agree to the terms and conditions of enrollment and to the Authorization to Obtain or Release Medical Information which appears above and on the reverse side of this application.

Employee Signature: \_\_\_\_\_ Date \_\_\_\_\_ Spouse/Partner Signature (if applicable) \_\_\_\_\_ Date \_\_\_\_\_

## 6. For Employer Use Only

Date of Hire	Effective Date	Is the employee currently working? <input type="checkbox"/> YES <input type="checkbox"/> NO	Hours Worked per week	Group/Division #
<input type="checkbox"/> New Hire <input type="checkbox"/> New Group <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> Family Status Change <input type="checkbox"/> Late Entrant <input type="checkbox"/> Annual Multi Carrier <input type="checkbox"/> Cancel All Coverage <input type="checkbox"/> Other		Describe Special Enrollment & attach documentation:	Date of Special Enrollment	Effective Date of Change
Reason for Change: <input type="checkbox"/> Elect Continuation/COBRA <input type="checkbox"/> Add Dependents listed above <input type="checkbox"/> Delete dependents listed above <input type="checkbox"/> Other				
Name of Employer	E-mail Address	Phone	Approved by	Date