

**Department of Finance
and Administration**

(PSORHHHR)

HHRU

This form must be returned to your Health Insurance Representative; not EBD.

**Public School Employees
Enrollment Form**

1. Employee Information: (please print)				<input type="checkbox"/> I decline coverage for myself	
Last Name		First Name		MI	Gender <input type="checkbox"/> Married <input type="checkbox"/> Single
Home Address		City		State	Zip Code
Social Security #:	Date of Birth:	Home #:		Work #:	
<input type="checkbox"/> Primary Care Physician:			PCP #	Current patient?	

2. Dependent Coverage Information:				<input checked="" type="checkbox"/> I decline coverage for my dependents		
DEPENDENT 1*	LAST NAME		FIRST NAME		MI	GENDER
	Social Security #:		Date of Birth:			
	<input type="checkbox"/> Primary Care Physician:			PCP #	Current patient?	
	LAST NAME		FIRST NAME		MI	GENDER
DEPENDENT 2*	Social Security #:		Date of Birth:		Full time student?**	
	<input type="checkbox"/> Primary Care Physician:			PCP #	Current patient?	
	LAST NAME		FIRST NAME		MI	GENDER
	Social Security #:		Date of Birth:		Full time student?**	
DEPENDENT 3*	<input type="checkbox"/> Primary Care Physician:			PCP #	Current patient?	
	LAST NAME		FIRST NAME		MI	GENDER
	Social Security #:		Date of Birth:		Full time student?**	
	<input type="checkbox"/> Primary Care Physician:			PCP #	Current patient?	
DEPENDENT 4*	LAST NAME		FIRST NAME		MI	GENDER
	Social Security #:		Date of Birth:		Full time student?**	
	<input type="checkbox"/> Primary Care Physician:			PCP #	Current patient?	
	LAST NAME		FIRST NAME		MI	GENDER

3. I Wish To Enroll In The Following Plan:	
<p>A. Select your level of coverage:</p> <p><input type="checkbox"/> Employee Only</p> <p><input type="checkbox"/> Employee & Spouse</p> <p><input type="checkbox"/> Employee & Children</p> <p><input type="checkbox"/> Family</p>	<p>B. Select your plan option:</p> <p><input type="checkbox"/> ARHealth - Health Advantage Network</p> <p><input type="checkbox"/> ARHealth - NovaSys Network</p> <p><input type="checkbox"/> ARHealth HDPPO - NovaSys Network</p>

ARHealth does not require you to select a Primary Care Physician (PCP) but it is highly recommended. By coordinating your personal health care through a single physician, you can help maintain a consistent level of service with a provider that understands your medical needs and situation.

* Please submit guardianship, court-ordered insurance responsibility or adoption papers on dependents that apply.

** To be completed for dependents 19 - 24 only. Please submit proof of student status.

4. Other Medical Insurance:

1) Will you or any of your family members be continuing any other health insurance? Yes No

2) If Yes, what type of coverage? Medical Medicare, HIC # _____

If Medicare: Part A Effective Date ____ / ____ / ____ or Part B Eff Date ____ / ____ / ____

If Medicare: Reason for Coverage: Over age 65 Disabled Kidney Disease

Please make sure EBD and your carrier has a copy of your Medicare card.

If you answered Yes to the question above, complete below: (Use additional paper if necessary)

Covered Person's Name	Coverage Type (single/family)	Effective Date	Policy Holder's Employer

Name/Address/Phone/Policy # of Health Ins Co.:

5. To Be Completed By School District:

School District #:	Name of School District:		
Employee #:	Hire Date:	Effective Date of Coverage:	

If employee is transferring from another agency/district, please provide name: _____

I have reviewed this Enrollment Form and believe that the requested action is in accordance with the

Print Name: _____

6. Please Read Before Signing:

I understand and agree that: (1) The information provided on this application is accurate and complete. (2) Any omissions or incorrect statements made by myself or anyone on this application may invalidate my and/or my dependents' coverage. (3) Coverage will become effective only on the _____ with other insurance I have that is subject to coordination. (5) I hereby authorize deductions from my earnings of any required insurance contribution. (6) That my eligibility and/or the eligibility of any covered dependents may be audited by EBD, or other designated party, at any time. (7) By signing this enrollment form, I hereby certify that all the information provided is true and correct.

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION: On behalf of myself and anyone enrolled on or added to this application, I authorize any health care professional or entity to give the health plan/insurer or any of their designees, any and all records or information pertaining to medical history or services rendered to the health plan/insurer, for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purpose, including evaluation of an application or a claim. I also authorize on behalf of health plan/insurer, the use of a Social Security Number for _____

Any person who knowingly obtains health coverage when not eligible for coverage, presents a false _____ repayment for plan losses/claims, or loss of health coverage for life.

I understand that if I refuse to apply now and I apply for coverage at a later date, my request may be deferred until open enrollment.

Employee's Signature: _____ Date: _____

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