

Membership Application & Change Form

Name of Employer: _____	Date of Full-Time Employment: _____
Group # /Rate Code: _____	Effective Date/Date of Change: _____

Coverage	Reason for Application/Change		
<input type="checkbox"/> HMO	<input type="checkbox"/> New Subscriber	<input type="checkbox"/> Address Change	Give addition/change explanations here: Dependent addition reason: Termination reason: Dependent termination reason: Other:
<input type="checkbox"/> POS	<input type="checkbox"/> Add Dependent	<input type="checkbox"/> Benefit Plan Change	
<input type="checkbox"/> NationCare	<input type="checkbox"/> Termination	<input type="checkbox"/> COBRA/Continuation	
<input type="checkbox"/> Network Options	<input type="checkbox"/> Dependent Termination	<input type="checkbox"/> Open Enrollment	
<input type="checkbox"/> Other	<input type="checkbox"/> Name Change	<input type="checkbox"/> Waiver of Insurance	

Employee Information				
Last Name: _____	Legal First Name: _____	Nickname: _____	MI: _____	Status (check)
Address/Apt. # : _____				<input type="checkbox"/> Single <input type="checkbox"/> Married
City: _____	State: _____	Zip: _____	<input type="checkbox"/> Hourly <input type="checkbox"/> Salary	
Home Phone: _____		Work Phone: _____		<input type="checkbox"/> Union <input type="checkbox"/> Non-union

Enrollment Section (attach additional sheets of paper if necessary)						
Name (Last, First, MI)	Birth date mm/dd/yr	Sex	Disabled	Relationship	Primary Care Practitioner Name (Strongly recommended)	Current Patient?
Self		M F	Y N	Self		<input type="checkbox"/> Yes <input type="checkbox"/> No
SSN # _____						
Sp.		M F	Y N	Spouse		<input type="checkbox"/> Yes <input type="checkbox"/> No
SSN # _____						
Dep 1		M F	Y N	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Grandchild <input type="checkbox"/> Guardianship		<input type="checkbox"/> Yes <input type="checkbox"/> No
SSN # _____						
Dep 2		M F	Y N	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Grandchild <input type="checkbox"/> Guardianship		<input type="checkbox"/> Yes <input type="checkbox"/> No
SSN # _____						
Dep 3		M F	Y N	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Grandchild <input type="checkbox"/> Guardianship		<input type="checkbox"/> Yes <input type="checkbox"/> No
SSN # _____						

Network Health Plan (NHP) and/or Network Health Insurance Corporation (NHIC), as applicable, requires all legal paperwork for insuring dependents involving guardianship and adoption.
 Visit networkhealth.com for an online Provider Directory to choose a Primary Care Physician for yourself and Dependents.

Other Insurance Coverage Information	
Do you or any Dependents have other group medical insurance including Medicare:	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, does this other policy include pharmacy coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Will this insurance continue after Network Health Plan begins?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Individuals who have other coverage:	Policyholder: _____
Name of Insurance Company:	Policy #: _____
Is there a divorce decree establishing insurance responsibility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Responsible Party: _____	Date of Birth: _____
Please provide Network Health Plan with a copy of the portion of the decree which states this responsibility.	

