

HIOS ID# _____
 EC _____

Commercial Group Health Insurance Application/Change Form

Please print clearly and complete all sections that apply. Signatures are required. Additional instructions included on Page 4.

Section 1: Employer Group & Benefit Information To be completed with your Group Administrator

Employer Name _____ Association/Chamber Name (if applicable) _____

Group Administrator's Signature (required) _____ Date _____ Employee Number _____ Department Number _____

Medical Information If enrolling in a Medical plan, who do you need coverage for?
 _____ Self Only
 _____ Self & Child(ren)
 _____ Self & Spouse, or
 _____ Self & Domestic Partner
 _____ Family
 _____ / _____ / _____
 Medical Group Number (8 digits)
 Medical Subgroup Number (4 digits)
 Medical Class Number (e.g. A001) Medical Effective Date

Medical Plan Selection

Birthdate : _____ / _____ / _____

Gender assigned at birth :
 Male
 Female

Social Security Number** _____

Date of Hire/Rehire: _____ / _____ / _____

Retirement Date: _____ / _____ / _____

Street Address _____

City _____ State _____

Zip Code _____ Phone _____

Subscriber's Medicare Number (if applicable) _____
 _____ / _____ / _____ Medicare Part A Effective Date
 _____ / _____ / _____ Medicare Part B Effective Date

Cancel Codes:

SB02-Left Employment SB05-Per Group Request SB06-Subscriber Request(voluntary) SB07-Deceased SB09-Enrolled in Error

Cancel Codes:

M001-Per Group Request M004-Enrolled in Error M008-Moved Out of Area M013-Ineligible
M002-Deceased M005-Divorced M010-Overage Dependent M014-YAO Ineligible
M003-Per Subscriber Request M007-Per Member Request(voluntary) M011-No Longer a Student M040-Mx Same Group

Spouse Domestic Partner Dependent Child Disabled Dependent Child (Separate application form required)
Other

Last Name (if different) Title First Name MI Social Security Number **

Gender assigned at birth : Male Female Birthdate / /
Gender identity (optional): Transgender Male Transgender Female Non-binary Prefer not to say Prefer to self-describe:

Is dependent a full-time student over age 19? Yes No Married? Yes No Expected Graduation Date: / /
If yes, please provide name of college/university Will dependent further education after graduation? Yes No

Medicare Eligible Yes No If yes, indicate reason Age 65+ Disability End Stage Renal
Part A Effective Date: / / Part B Effective Date: / /
Medicare Number (if applicable)

Dependent Child Disabled Dependent Child (Separate application form required) Other

Last Name (if different) Title First Name MI Social Security Number **

Gender assigned at birth : Male Female Birthdate / /

Married

Have you or any member of your family been enrolled in other medical or dental coverage? Yes No

If yes, what type of coverage? Medical Dental

What is the effective date of the other coverage? Medical: ___/___/___ Dental ___/___/___

What is the name of the other carrier? _____

Are you keeping the coverage? Yes No

If no Yes No

Instructions for completing the Group Health Insurance Application/Change Form

Section 1: Employer Group & Benefit Information

This section should be completed with your Group Administrator. Group Administrator's signature is required. Medical and/or dental group numbers and information must be populated. Select who you need coverage for on the medical and/or dental plan(s) and indicate the subscriber's status. Next, select the medical and/or dental plan(s) you are enrolling in. All products may not be applicable to your employer group. Please check with your Group Administrator.

Section 2: Subscriber's