AmeriHealth.

SEH Enrollment Form

1 Subscriber Information – Please complete this entire section, whether you are a new applicant or are making a change to an existing contract.

Social Security Number or ID Number ☐ | Last Name ☐ | First Name ☐ | M.I. ☐ | Gender: ☐ Male ☐ Female

Street Address ☐ | Apartment or Suite | City ☐ | State ☐ | ZIP Code ☐

Telephone Number including Area Code
Home ☐
Work ☐

Are you actively at Work? ☐ Yes ☐ No
If no, please explain. ____________

Date of Hire ☐ | Hours Worked per Week ☐ | Date of Birth ☐

Occupation ____________
Title ____________

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Primary Care Office Number ☐
Primary Care Office Name ____________
Check if current patient. ☐

Primary Dental Office Number ☐
Primary Dental Office Name ____________
Check if current patient. ☐

2A Select Plan – Please select only coverages offered by your employer.

☐ HMO ☐ PPO ☐ Open Access ☐ Vision ☐ Dental
☐ POS ☐ CMM ☐ Open Access Plus ☐ Rx

2B Coverage Information

Persons to be covered by this plan:
☐ Employee Only ☐ Employee and Child(ren)
☐ Employee and Spouse ☐ Employee, Spouse and Child(ren)

3 Dependent Information – Please provide all information for each person to be covered. Please attach additional sheets if required.

Spouse Last Name ☐ | First Name ☐ | M.I. ☐ | Gender ☐ | Date of Birth ☐
Social Security Number ☐ | Primary Care Office Number ☐ | Primary Care Office Name ____________ | Check if current patient. ☐ | Primary Dental Office Number ☐ | Check if current patient. ☐
Will other health insurance be in effect? If yes, see 4. ☐ Yes ☐ No
Dependent over 19? Provide verification.

Child Last Name ☐ | First Name ☐ | M.I. ☐ | Gender ☐ | Date of Birth ☐
Social Security Number ☐ | Primary Care Office Number ☐ | Primary Care Office Name ____________ | Check if current patient. ☐ | Primary Dental Office Number ☐ | Check if current patient. ☐
☐ Yes ☐ No | ☐ Student ☐ Disabled

Child Last Name ☐ | First Name ☐ | M.I. ☐ | Gender ☐ | Date of Birth ☐
Social Security Number ☐ | Primary Care Office Number ☐ | Primary Care Office Name ____________ | Check if current patient. ☐ | Primary Dental Office Number ☐ | Check if current patient. ☐
☐ Yes ☐ No | ☐ Student ☐ Disabled

Child Last Name ☐ | First Name ☐ | M.I. ☐ | Gender ☐ | Date of Birth ☐
Social Security Number ☐ | Primary Care Office Number ☐ | Primary Care Office Name ____________ | Check if current patient. ☐ | Primary Dental Office Number ☐ | Check if current patient. ☐
☐ Yes ☐ No | ☐ Student ☐ Disabled

4 Other Insurance Information

List health insurance information for you or any dependents with other coverage.

Carrier Name

Policy Holder

Policy Number ______ Type of benefits ______

Which coverage have you selected to be primary in the event expenses are incurred as a result of an automobile related injury? ☐ Auto ☐ Medical

Indicate whether any person to be covered is enrolled under Medicare Part A or B.

Name	Medicare Number	
		☐ Part A ☐ Part B
		☐ Part A ☐ Part B
		☐ Part A ☐ Part B

5 Dependent Information – If you listed dependents, you MUST answer these questions.

Do any dependents listed live at another address? Yes ☐ No ☐

Is any dependent's last name different from yours? Yes ☐ No ☐

If you answered yes to either question, please explain. ______

6 Group and Employer Information

Your Group Administrator **MUST** complete this section. Your application **CANNOT** be processed unless this section is complete.

Group Name

Group Number

Account Number

Plan Co-Pay (if applicable)

Payroll / Work Location

Employer or Group Administrator Signature

Date

7 Declaration, Authorization and Conditions of Acceptance

Please read carefully and sign below. Your application **CANNOT** be processed without your signature.
Any person who knowingly and with intent to defraud any insurance company submits to an insurer a written or oral statement of claim or benefit containing any materially false information or conceals for the purpose of misleading, information concerning any material fact commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For PPO and CMM Members
By signing this application, I elect coverage under the plan specified on this form and for the persons listed here and agree to abide by the conditions of the agreement and to pay required premiums for the selected plan. I authorize my licensed physician, medical or medically related facility, insurance company or other organization or institution that has any records concerning my health or the health of any covered family member to forward such information to AmeriHealth. This application is subject to acceptance and to the waiting periods, exclusions, and all other provisions contained in the agreement between my Employer, Association or Welfare board and AmeriHealth.

For HMO and POS Members
I understand that the provision of services to me and my dependents as Members of AmeriHealth is governed by the applicable Master Group Contract, which provides that: 1) except for emergencies, all medical or dental care must be initiated at the primary care office or primary care dental office we have selected; and, 2) I and my dependents authorize any person or organization providing services to furnish AmeriHealth with medical or dental records or other information concerning such services for purposes of AmeriHealth quality and utilization review. I understand that if I choose a Point of Service Product, I will be subject to applicable deductible, coinsurance and other copayments for all non-referred service, as specified in the contract. I further understand that I can change health plan coverage only at the time my employer and AmeriHealth specify.

Employee Signature

Date ______

8 Additional Information

Please indicate the reason for completing this form.

New	Change	Life Event Change	Other Change	Terminate Contract
☐ New Group	☐ Address	☐ Marriage	☐ COBRA	☐ Terminated Employment
☐ Open Enrollment	☐ Last Name	☐ Add a Dependent	Effective Date ______	☐ Full Time to Part Time
☐ Life Event	☐ Primary Care Office	☐ Delete a Dependent	**Effective Date of Coverage**	☐ Deceased. Date ______
☐ New Hire	☐ Dental Office	Life Event Date ______		☐ Other. Please explain. ______
	☐ Rehire			