HERITAGE CONSULTANTS/PROFESSIONAL ADMINISTRATORS

COVERAGE ENROLLMENT FORM

Hire Date:	**ORIGINAL Effective Date From: To:**

If you are currently enrolled on medical plan, and continuing coverage, please note "To" date as "Present"

Employer: **COMPANY NAME** Location:__________________ Class:______________________

Employee Name:___________________________________ Job Title:_________________SS#: ________________________

Employee Street Address:___________________________ Sex: M______ or F_____ Birth Date: ____/_____/_____

City:________________________ ST:_____ Zip:________ Marital Status: Single Married Divorced Widowed

SELECT COVERAGE:

	Medical /Rx Card	**Dental**	**Vision**	**Network**
Employee only	______	______	______	______Sagamore Plus
Employee + Spouse	______	______	______	______Evolutions
Employee + Child/ren	______	______	______	______PHCS
Employee + Family	______	______	______	______Other ___________

DEPENDENTS TO BE COVERED

NAME	SS NUMBER	DOB	SEX (M/F)	RELATION TO EMPLOYEE

OTHER COVERAGE:

Are you or any of your dependents covered under any other health insurance? **Yes** **No**

If yes, please list below the name and address of the insurance company, the policy number, and the name of the person insured. **This information must be furnished in order for any claims to be processed.**

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PLAN ELECTION:

______ **Option # 1** $?? Single/$?? Family deductible (2x Out-Of-Network), 80/60 coinsurance, $?? Single/$?? Family Out-Of-Pocket (2x Out-Of-Network), $?? OV copay, $?? Specialist copay, $?? Urgent Care copay, $?? ER copay, $??/$??/$?? Rx copays ($??/$??/$?? mail order), $??M lifetime maximum.

______ **Option # 2** $?? Single/$?? Family deductible (2x Out-Of-Network), 80/60 coinsurance, $?? Single/$?? Family Out-Of-Pocket (2x Out-Of-Network), $?? OV copay, $?? Specialist copay, $?? Urgent Care copay, $?? ER copay, $??/$??/$?? Rx copays ($??/$??/$?? mail order), $??M lifetime maximum.

Terms noted are not a guarantee of coverage. Please refer to the Summary Plan Description (SPD) for full details on plan services and coverage.

BENEFIT ELECTIONS

________I wish to enroll in the above benefit programs as shown.

________I acknowledge that these benefits have been offered to me and I **do not** wish to enroll in the benefit programs.

I Hereby authorize any hospital, physician, or other person who has furnished medical services or supplies to me or my dependents to disclose to HERITAGE CONSULTANTS/PROFESSIONAL ADMINISTRATORS, when requested to do so, the following information; any and all information with respect to any illness, injury, medical history, consultation, prescription, or treatment. This also includes copies of all hospital or medical records. I further authorize HERITAGE CONSULTANTS/PROFESSIONAL ADMINISTRATORS to release all such information/records to any agent, broker, or other necessary representative of my employer for purposes of claim administration and underwriting. A photocopy of this authorization shall be considered as effective and valid as the original.

EMPLOYEE SIGNATURE: ________________________________ Date: ______________________