



Adventist Risk Management, Inc.

EMPLOYEE HEALTH CARE ENROLLMENT APPLICATION

Employee Instructions: Complete the entire application **except the employer section of this page**. Return your completed application within five days to your employer. Benefits will be withheld until application is received.

EMPLOYEE INFORMATION:

Group # :	Subgroup # :	Employer:	Employee's E-Mail Address:		
Social Security Number:		First Name:	M. I.	Last Name:	
Address 1			Department:		
Address 2			Work Phone:		
City	State	Zip	Home Phone:		
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate MO DA YR	Previous Employer:	Hire Date MO DA YR	Effective Date:	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single

SPOUSE INFORMATION:

Spouse First Name:		M.I.	Spouse Last Name:	
Spouse Birthdate: MO DA YR	Spouse Social Security Number:	Is Spouse Employed: <input type="checkbox"/> Yes <input type="checkbox"/> No		Spouse's Employer: Name _____ Phone # _____
Other Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No	Dependents Covered: <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Insurance:		
Policy Number		Effective Date		

DEPENDENT INFORMATION:

Relationship	First Name	Last Name	Birthdate	Full-Time Student	Child's SS #
<input type="checkbox"/> Son <input type="checkbox"/> Daughter					
<input type="checkbox"/> Son <input type="checkbox"/> Daughter					
<input type="checkbox"/> Son <input type="checkbox"/> Daughter					
<input type="checkbox"/> Son <input type="checkbox"/> Daughter					

EMPLOYER INSTRUCTIONS TO BENEFIT PLAN ADMINISTRATOR:

	Name	Effective Date	Primary/Secondary				Received On:	
			Medical	Dental	Vision	Rx		DATE COMPLETED
Employee								
Spouse								
Dependent Children								
1.								
2.								
3.								
4.								

OFFICE USE ONLY

FOR ARM OFFICE USE

OFFICE USE ONLY

Employer Signature: _____ Date: _____ Coverage Code _____

HOSPITALIZATION/GENERAL MEDICAL

Policy Type	Plan Covers	Plan Description	Employee	Spouse	Dependent
N	Employee Only	Coverage for employee only.	X	-	-
S	Employee + Spouse	Coverage for employee and spouse.	X	X	-
C	Employee & Child(ren)	Coverage for employee and child(ren).	X	-	X
F	Family	Coverage for employee, spouse, and child(ren).	X	X	X

EMPLOYEE AUTHORIZATION AND CERTIFICATION

I authorize all providers of health care to furnish all records pertaining to medical history, services and rendered treatment given as pertains to evaluation of enrollment application and/or claims. This authorization will become effective immediately and will remain in effect as long as necessary to enable Adventist Risk Management Inc to process the application and/or claims.

I agree to notify my employer of any changes in family status or eligibility of family members. Failure to notify my employer of any status changes will authorize my employer to ask ARM Inc to deny payments of future claims and ask for collection of past paid claims for ineligible spouse or dependents.

I certify that all of the above information is complete and correct.

Employee Signature

Date Signed