



4—Subscriber Information - continued

Primary Care Physician's Last Name

[Grid for Primary Care Physician's Last Name]

Primary Care Physician's First Name

[Grid for Primary Care Physician's First Name]

Primary Care Physician Number

[Grid for Primary Care Physician Number]

Are you a current patient, or if not a current patient, have

you verified that the PCP will accept you as a new patient?

Yes  No

Name of Prior Health Care Insurer

[Grid for Name of Prior Health Care Insurer]

Do you have additional group health insurance?

Yes  No

Policy Identification Number

[Grid for Policy Identification Number]

Policy Effective Date (MMDDYY)

[Grid for Policy Effective Date]

Policy Cancellation Date (MMDDYY)

[Grid for Policy Cancellation Date]

5—Dependent Information Please provide all information for each person to be covered.

Spouse/Domestic Partner's Last Name

[Grid for Spouse/Domestic Partner's Last Name]

Spouse/Domestic Partner's First Name

[Grid for Spouse/Domestic Partner's First Name]

M.I.

[Grid for M.I.]

Social Security Number

[Grid for Social Security Number]

Date of Birth (MMDDYY)

[Grid for Date of Birth]

Male

Are you enrolling as a Domestic Partner?

Female

Yes  No

E-mail Address

[Grid for E-mail Address]

Medicare Eligible Please indicate reason for Medicare eligibility:  Age 65+  Disability  End Stage Renal Disease

Medicare Number (if applicable)

[Grid for Medicare Number]

Part A Effective Date (MMDDYY)

[Grid for Part A Effective Date]

Part B Effective Date (MMDDYY)

[Grid for Part B Effective Date]

Part D Effective Date (MMDDYY)

[Grid for Part D Effective Date]

Primary Care Physician's Last Name

[Grid for Primary Care Physician's Last Name]

Primary Care Physician's First Name

[Grid for Primary Care Physician's First Name]

Primary Care Physician Number

[Grid for Primary Care Physician Number]

Are you a current patient, or if not a current patient, have

you verified that the PCP will accept you as a new patient?

Yes  No

Name of Prior Health Care Insurer

[Grid for Name of Prior Health Care Insurer]

Do you have additional group health insurance?

Yes  No

Policy Identification Number

[Grid for Policy Identification Number]

Policy Effective Date (MMDDYY)

[Grid for Policy Effective Date]

Policy Cancellation Date (MMDDYY)

[Grid for Policy Cancellation Date]

Dependent's Last Name

[Grid for Dependent's Last Name]

Dependent's First Name

[Grid for Dependent's First Name]

M.I.

[Grid for M.I.]

Social Security Number

[Grid for Social Security Number]

Date of Birth (MMDDYY)

[Grid for Date of Birth]

Male

Is your over-age dependent handicapped?

Female

Yes

No

E-mail Address

[Grid for E-mail Address]

Medicare Eligible Please indicate reason for Medicare eligibility:  Age 65+  Disability  End Stage Renal Disease

Medicare Number (if applicable)

[Grid for Medicare Number]

Part A Effective Date (MMDDYY)

[Grid for Part A Effective Date]

Part B Effective Date (MMDDYY)

[Grid for Part B Effective Date]

Part D Effective Date (MMDDYY)

[Grid for Part D Effective Date]

Is dependent a full-time student?  Yes  No

If yes, please indicate college/university name:

College/University Name

[Grid for College/University Name]

Expected Graduation Date (MMDDYY)

[Grid for Expected Graduation Date]

Primary Care Physician's Last Name

[Grid for Primary Care Physician's Last Name]

Primary Care Physician's First Name

[Grid for Primary Care Physician's First Name]

Primary Care Physician Number

[Grid for Primary Care Physician Number]

Are you a current patient, or if not a current patient, have

you verified that the PCP will accept you as a new patient?

Yes  No

Name of Prior Health Care Insurer

[Grid for Name of Prior Health Care Insurer]

Do you have additional group health insurance?

Yes  No

Policy Identification Number

[Grid for Policy Identification Number]

Policy Effective Date (MMDDYY)

[Grid for Policy Effective Date]

Policy Cancellation Date (MMDDYY)

[Grid for Policy Cancellation Date]



