

HIP Subscriber/Member Enrollment Form

Last Name: _____ M.I.: _____ Sex: _____ Social Security Number: _____
 Street Address: _____ City: _____ State: _____ Zip Code: _____
 Were you ever a member of HIP? NO YES
 If yes, indicate member ID number(s): _____ Work: () _____
 Telephone #: Home: () _____
 E-Mail Address: _____
 Birth Date: _____
 Marital Status: Single Married Divorced
 Apt. _____ City: _____
 New Hire Loss of Coverage Marriage

Qualifying Event: Birth/Adoption Marriage New Hire Loss of Coverage Marriage New Hire Loss of Coverage
 Qualifying Event Date: Mo. ___ Day ___ Yr. ___
Are you covered by any other Health Insurance or Medicare?
 NO YES If yes, indicate:
 Insurance Co. Name: _____
 Insurance Co. Telephone #: _____
 Type of Coverage: _____
 Policy #: _____ Effective Date: ___/___/___
Is your spouse covered by any other Health Insurance or Medicare?
 NO YES If yes, indicate:
 Insurance Co. Name: _____
 Insurance Co. Telephone #: _____
 Type of Coverage: _____
 Policy #: _____ Effective Date: ___/___/___

*** If you are enrolling for your spouse and/or children, please list each one below - see Election of Coverage for eligibility**

Last Name (if different)		OB/GYN Selection Name/Number (Optional)	Physician Name	Physician ID Number	Carrier Name	Coverage Begin Date	Coverage End Date
SPOUSE							
First Name		Soc. Sec. No.	Sex	Relationship	Birth Date	Check if disabled	OB/GYN Selection Name/Number (Optional)
Prior Health Insurance Information		Carrier Name			Mo. ___ Day ___ Yr. ___		
Additional Dependents (List oldest first)							
Prior Health Insurance Information		Carrier Name					
Prior Health Insurance Information		Carrier Name					
Prior Health Insurance Information		Carrier Name					
Prior Health Insurance Information		Carrier Name					
Prior Health Insurance Information		Carrier Name					

Your signature is required to process this form. Your signature attests that you have read the reverse side of this form

Applicant must sign here: _____ Date: _____

THIS SECTION TO BE COMPLETED BY EMPLOYER/CONTRACTOR GROUP

Name of Group: _____ Group Number: _____

Requested Effective Date: _____ Hire Date: _____ Employee Title: _____ Date Submitted to HIP: _____ Approved by (Representative of Benefits Administrator): _____

Select One: HIP PRIME HMO HIP access I HIP PRIME EPO
 HIP PRIME POS HIP access II HIP PRIME PPO
 HIP SELECT EPO HIP SELECT PPO HIP CLASSIC HMO

Type of Coverage: Individual Family Employee & Spouse Employee & Child

Instructions to Benefit Administrators or Group Representatives: For Groups with 50 employees or less, you **MUST** complete Section A on the reverse side of this form. Required documentation **MUST** be attached to this Enrollment Form to be processed.

PROCESSED BY: _____ RECEIVED DATE: _____ FOR HIP USE ONLY
 PROCESSED DATE: _____