



NORTHWESTERN  
UNIVERSITY

# Health Plan Enrollment Form

(The Benefits Division will accept original forms only)

COBRA Participants

<b>ACTION</b>		<b>MEMBERSHIP INFORMATION</b>	
<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Former Employee	
<input type="checkbox"/> Dropping Dependents	<input type="checkbox"/> Address Change	<input type="checkbox"/> Dependent/Spouse	
<input type="checkbox"/> Terminate Coverage	<input type="checkbox"/> Other		

## PERSONAL INFORMATION

NAME		EMPLOYEE ID		GENDER	
Last	First	M.I.	_____	<input type="checkbox"/> Male	<input type="checkbox"/> Female
HOME ADDRESS		Apt.	City	State	Zip
Street					
DATE OF BIRTH:	CHANGE EFFECTIVE DATE:	E-MAIL:		HOME PHONE:	
___/___/___	___/___/___			(____) _____ - _____	
MARITAL STATUS: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed					

## HEALTH PLAN SELECTION

Please select the health plan and type of coverage you wish to enroll in:

I ELECT TO:		<input type="checkbox"/> Premier PPO		<input type="checkbox"/> HMO Illinois	
<input type="checkbox"/> continue <input type="checkbox"/> drop <input type="checkbox"/> change		<input type="checkbox"/> Select PPO		<input type="checkbox"/> UniCare HMO	
HEALTH INSURANCE COVERAGE		<input type="checkbox"/> Value PPO		<input type="checkbox"/> You <input type="checkbox"/> You + child(ren)	
				<input type="checkbox"/> You + spouse <input type="checkbox"/> You + spouse + child(ren)	
Office Use Only: <input type="checkbox"/> Entered into HRIS <input type="checkbox"/> Submitted to Provider		Coverage Effective Date		Group and Section Number	
Plan <b>cannot</b> be changed at initial enrollment					

## OTHER INSURANCE INFORMATION

Do you or any of your family members have other Group Health or Dental Insurance?  Yes  No If yes, please complete the following:

NAME OF INSURED:		EMPLOYER:		POLICY NUMBER:	
INSURANCE COMPANY NAME:		INSURANCE COMPANY ADDRESS:			
Are you covered by Medicare? <input type="checkbox"/> YES <input type="checkbox"/> NO		Is your spouse? <input type="checkbox"/> YES <input type="checkbox"/> NO		If over 65: <input type="checkbox"/> Presently employed <input type="checkbox"/> Retired	

## DEPENDENT INFORMATION

please select whether you want your dependent to be covered under your Health plan

Relationship	Date of Birth	Name (Last [if different], First MI)	Continue/Drop
<input type="checkbox"/> Spouse <input type="checkbox"/> Dom Partner	___/___/___		<input type="checkbox"/> Continue <input type="checkbox"/> Drop
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	___/___/___		<input type="checkbox"/> Continue <input type="checkbox"/> Drop
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	___/___/___		<input type="checkbox"/> Continue <input type="checkbox"/> Drop
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	___/___/___		<input type="checkbox"/> Continue <input type="checkbox"/> Drop

## AUTHORIZATION

(1) I elect coverage under the above-selected Health Plan on behalf of myself and the above-listed dependents. (2) I certify that the above information is correct to the best of my knowledge and belief. (3) I hereby authorize any licensed physician, hospital, clinic, government agency or other health or medically-related facility, insurance company, organization or institution that has any records or knowledge of my health or the health of any member of my family to exchange such information with the above-selected health care provider—including, without limitations, information relating to mental illness or use of drugs or alcohol. I understand that the information will be used for the purpose of review, investigation, or evaluation of coverage claims for health insurance benefits provided to me and/or any of my dependents. (4) I agree to abide by the terms and conditions of the Plan Document and Certificates of Insurance. This authorization is valid for the term of coverage of the contract under which this Health Plan enrollment is effective. I am aware of my right to receive a copy of the authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

SIGNATURE

DATE