



NORTHWESTERN UNIVERSITY

Health Plan Enrollment Form

COBRA Participants

Health Insurance Enrollment and Policy Change Form

MEMBERSHIP

<input type="checkbox"/> Former Employee <input type="checkbox"/> Dependent/Spouse	ACTION: <input type="checkbox"/> New Enrollment <input type="checkbox"/> Name Change <input type="checkbox"/> Dropping Dependents	<input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> Address Change	<input type="checkbox"/> Change HMO Physician Group
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PERSONAL INFORMATION

NAME Last		First		M.I.	SOCIAL SECURITY # ____-____-____		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
HOME ADDRESS Street		Apt.		City		State	Zip	
DATE OF BIRTH: __/__/__		DATE OF HIRE: __/__/__		E-MAIL:		HOME PHONE: (____) ____-____		CAMPUS 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"/> continue <input type="checkbox"/> drop <input type="checkbox"/> change HEALTH INSURANCE COVERAGE		If you are selecting an HMO, please refer to the plan brochure and indicate the Participating Medical Group and Group Number (if applicable). If you select an HMO, please designate a primary care physician for yourself and each family member.						
<input type="checkbox"/> Premier PPO <input type="checkbox"/> Select PPO <input type="checkbox"/> Value PPO <input type="checkbox"/> HMO Illinois <input type="checkbox"/> UniCare HMO		Health Center or Physician Group Name:		Number		Primary Care Physician		
<input type="checkbox"/> You <input type="checkbox"/> You + spouse		<input type="checkbox"/> You + child(ren) <input type="checkbox"/> You + spouse + children						
Office Use Only: <input type="checkbox"/> Entered into HRIS <input type="checkbox"/> Submitted to Provider		Coverage Effective Date				Group and Section Number		

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 and/or Dental plan

Relationship	Date of Birth	Name (Last [if different], First MI)	Social Security #	HMO Primary Care Physician	Add/Drop	Health/Dental
<input type="checkbox"/> Spouse <input type="checkbox"/> Dom Partner	__/__/__		____-____-____		<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Health
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	__/__/__		____-____-____		<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Health
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	__/__/__		____-____-____		<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Health
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	__/__/__		____-____-____		<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Health

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