

Coordination of Benefits Information ONLY:

Are you or any member of your family going to have health coverage **in addition** to this health plan? Yes No *If yes, please complete the following:*

Name of covered members:

Member Name	Med Dent Vision	/	/	Group / Individual
	Type of Coverage	Effect. Date		Circle Policy

Name of Carrier

Member Name	Med Dent Vision	/	/	Group / Individual
	Type of Coverage	Effect. Date		Circle Policy

Name of Carrier

Member Name	Med Dent Vision	/	/	Group / Individual
	Type of Coverage	Effect. Date		Circle Policy

Name of Carrier

Provide the following information on the carriers listed above:

Carrier Name	Carrier Phone #:	Policy Number
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Street Address	Apt	City	State	Zip Code
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Subscriber Name	SS#	DOB
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Employer Name (if group coverage)	Street Address	City	State	Zip Code
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Marital Status: Single Married _____ Widowed Legally Separated Divorced

Name of Spouse

If divorced, is there a court order for provision of the child? Yes No *If yes, attach a copy of the court decree. Per the Court Decree:*
 Who has custody of child? _____ Who needs to provide insurance for child? _____

List the full name(s) of child(ren) _____

List both natural parents: Nat. Father _____ DOB _____ Nat. Mother _____ DOB _____

Is employee, spouse/domestic partner covered under this medical plan eligible for Medicare Benefits? Yes No

If yes, enter date of eligibility for Medicare Part A ___/___/___ or for Part B ___/___/___ SS# _____

I certify that the above listed information is correct and that I am enrolling only eligible dependents as defined in the Plan Document. I understand that all entitlements to benefits are void, and coverage may be canceled or modified retroactively to its effective date, if I have made intentionally false or misleading statements or answers on behalf of myself or any family members. I authorize any person or institution providing care or services, or any organization in possession of insurance benefit information to release any and all information pertaining to the care or benefits provided to me or my dependents to Healthcare Management Administrators or its designated agent.

I acknowledge and understand that my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law. *

Health information requested or disclosed may be related to treatment or services performed by: 1) A physician, dentist, pharmacist or other physical or behavioral health care practitioner; 2) A clinic, hospital, long term care or other medical facility; 3) Any other institution providing care, treatment, consultation, pharmaceuticals or supplies; or 4) An insurance carrier or group health plan. Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

This acknowledgement does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.
 * For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Privacy Notice. A copy is available upon request.

Employee's Signature	Date Signed
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Employee Printed Name	Social Security #
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