ENROLLMENT APPLICATION

Effective Date ____/____/____

Medical Associates Health Plan, Inc.
1605 Associates Drive
Dubuque, Iowa 52002
563-584-4885 or toll-free 1-866-821-1365
E-mail: memberservices@mahealthcare.com

MEDICAL ASSOCIATES

☐ NEW ENROLLMENT or
☐ CHANGE NOTICE

☐ Add dependents-list dependent(s) to add in Section B
☐ Remove dependents-list dependent(s) to remove in Section B
☐ Reason for adding or deleting members _____
☐ Effective Date of Change_____
☐ Cancel Coverage Effective_____
☐ COBRA
☐ Change Name from _____ (list new name in Section A or B)
☐ Change of Address_____ (list new address in Section A)
☐ Other (specify)_____
☐ Waive Coverage

CHANGE COVERAGE TO:

TYPE OF COVERAGE:
☐ Single
☐ Employee + Spouse
☐ Employee + Child(ren)
☐ Family

THIS APPLICATION MUST BE COMPLETED IN FULL FOR ALL NEW ENROLLMENTS **Plan/Network** _____

SECTION A: SUBSCRIBER DATA

EMPLOYER NAME	DATE EMPLOYED	DIVISION #	MARITAL STATUS
			☐ Single ☐ Divorced ☐ Widow ☐ Married ☐ Legally Separated
LAST NAME	MAIDEN NAME	FIRST NAME / INITIAL	
STREET ADDRESS	CITY	STATE	ZIP
			_____ - _____
COUNTY	SOCIAL SECURITY NO.	PHONE NUMBER ( )	DATE OF BIRTH _____/_____/_____	GENDER ☐ Male ☐ Female
E-MAIL ADDRESS	RACE ☐ DECLINE TO ANSWER	ETHNICITY ☐ DECLINE TO ANSWER		

SECTION B: SPOUSE/DEPENDENT DATA

NAME (Last, First, Middle Initial)	DATE OF BIRTH	GENDER	SOCIAL SECURITY NUMBER
SPOUSE			
	RACE ☐ DECLINE TO ANSWER		ETHNICITY ☐ DECLINE TO ANSWER
DEPENDENT			
	RACE ☐ DECLINE TO ANSWER		ETHNICITY ☐ DECLINE TO ANSWER
DEPENDENT			
	RACE ☐ DECLINE TO ANSWER		ETHNICITY ☐ DECLINE TO ANSWER
DEPENDENT			
	RACE ☐ DECLINE TO ANSWER		ETHNICITY ☐ DECLINE TO ANSWER
DEPENDENT			
	RACE ☐ DECLINE TO ANSWER		ETHNICITY ☐ DECLINE TO ANSWER

Race Categories: White, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander, Some Other Race, Two or More Races, and Unknown.

Ethnicity Categories: Hispanic or Latino, Not Hispanic or Latino, and Unknown

SECTION C: COORDINATION OF BENEFITS

IS YOUR SPOUSE EMPLOYED? ☐YES ☐NO NAME OF EMPLOYER_____ CITY/STATE OF THE EMPLOYER_____

IS YOUR SPOUSE COVERED UNDER A GROUP HEALTH POLICY WITH THAT EMPLOYER ☐YES ☐NO	ARE YOU AND/OR ANY DEPENDENT CHILDREN ALSO COVERED UNDER YOUR SPOUSE'S POLICY? ☐YES ☐NO
IF "YES" TO THE ABOVE QUESTION, WHAT IS THE NAME OF THE INSURANCE COMPANY, AND LIST FIRST NAMES OF ALL PERSONS COVERED (if there is a court-ordered document, please send a copy):	ARE ANY OF THE FOLLOWING ELIGIBLE FOR MEDICARE? ☐SELF ☐SPOUSE ☐DEPENDENT

WILL YOUR SPOUSE'S COVERAGE REMAIN IN EFFECT WHEN THIS COVERAGE IS EFFECTIVE? ☐YES ☐NO	IF YES, WHAT IS THE NAME OF THE INSURANCE COMPANY?	IF NO, WHEN WILL COVERAGE TERMINATE? _____/_____/_____

To the best of my knowledge, the above information is complete and true, and I understand that falsification by me will allow my employer's group health plan to recover payments made, cancel my coverage and/or refuse payment of claims. Updates or additions to this information may be required periodically. I hereby request the amount(s) and Forms of Coverage for which I am or may become eligible and hereby authorize my employer to deduct any required contributions from my earnings (pre-tax, if applicable). By signing, I authorize all physicians, Ph.Ds, hospitals, druggists and all agencies including other claim administrators, to furnish to MAHP full information pertaining to the diagnosis and treatment of medical, mental health, and drug and alcohol conditions. I understand that the purpose or need for this disclosure is to verify eligibility of benefits, I also understand that this consent is subject to revocation at any time through a written submission to MAHP.

Signature _____ **Date** _____

MEDICAL ASSOCIATES HEALTH PLAN, INC.

Medical Associates Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-821-1365 (TTY: 1-800-735-2942).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-821-1365 (TTY: 1-800-735-2942)。

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-821-1365 (TTY: 1-800-735-2942).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-866-821-1365 (TTY: 1-800-735-2942)