

# Preferred Health Systems Insurance Company ("PHSIC") High Deductible Health Plan Enrollment Form

PLEASE TYPE OR PRINT

SSN	Employee's Legal First Name		Legal First Name		MI
Street Address	City	State	Zip Code		
Home Phone	Work Phone	Birth Date	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Common Law Married	Your Employer/Company Name Group Number

**PLEASE LIST SPOUSE YOU WISH TO ENROLL IN MEDICAL COVERAGE (if common law married attach affidavit)**

Last Name	First Name	MI	Birth Date	Sex	SSN
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**PLEASE LIST CHILDREN AND OTHER ELIGIBLE DEPENDENTS YOU WISH TO ENROLL IN MEDICAL COVERAGE**

Last Name	First Name	MI (List address if different)	Birth Date	Sex	SSN	Relationship	Full Time College Student (Please attach schedule) <input type="checkbox"/> Yes <input type="checkbox"/> No

Are you or any person listed above totally disabled?  Yes  No If so, who is disabled? \_\_\_\_\_

After you are enrolled in PHSIC, will you or any person above be covered by other health insurance?  Yes  No If yes, what insurance \_\_\_\_\_

Insurance Company phone number \_\_\_\_\_ Policyholder's Name \_\_\_\_\_ Policyholder's Date of Birth \_\_\_\_\_ Policyholder's ID# \_\_\_\_\_

Names of those covered \_\_\_\_\_

When selecting a qualified high deductible health plan, I understand that I am required to establish a federally qualified health savings account on the effective date of the policy. \_\_\_\_\_ (please initial) I hereby apply for enrollment for the individual(s) listed above. I authorize my employer to deduct from my earnings my contribution to the premium. I hereby consent to the release of information or medical records concerning services or supplies provided to me or my covered dependents by any health care provider, allied health professional, hospital or medical care institution to PHSIC or its designee for the purpose of quality or utilization review or payment of a claim. A copy of this consent is available upon request. The consent is valid for the duration of the coverage. I represent that the information I have provided on this form is correct and that I do hereby agree to the terms and conditions set out in the plan.

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

**MUST BE COMPLETED BY EMPLOYER**

Date of Employment: \_\_\_\_\_ Please check one of the following: New Hire \_\_\_\_\_ Open Enrollment \_\_\_\_\_ Loss of other group coverage \_\_\_\_\_ Date of loss \_\_\_\_\_ Other \_\_\_\_\_ Please list reason such as: change in family status, PT to FT, Loss of other coverage \_\_\_\_\_ Date of Qualifying Event \_\_\_\_\_

Effective Date of Coverage \_\_\_\_\_ Employer Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

Preferred Health Systems Insurance Company • P.O. Box 49288, Wichita, KS 67201-9288 • 316-609-2390 • Outside Sedgwick Co. 1-800-660-8114 • Fax 316-609-2327

White: Preferred Health Systems Insurance Company Copy Yellow: Employer Copy Pink: Employee Copy/Temporary Identification Card



an affiliated company of