CHP USE ONLY:

Contract Number: ____________
Group ID: ____________
Member ID: ____________

ENROLLMENT APPLICATION

Initial Enrollment (New Hire): ☐ | Open Enrollment: ☐ | **OR** Special Enrollment: ☐ * Please list the Qualifying Event and provide supporting documentation: ____________

1. Type of Coverage Applying For: ☐ Single ☐ Employee & Spouse ☐ Employee & Children ☐ Family

2. SSN:	**3. Last Name:**	**4. First Name:**	**5. M.I.:**

6. Physical Address:

Street City State Zip Code County

7. Mailing Address: (If different from above)

Street City State Zip Code County

8. Date of Birth:	**9. Sex:** ☐ Female ☐ Male	**10. Marital Status:** ☐ Married ☐ Widowed ☐ Single ☐ Divorced ☐ Legally Separated	**11. Home PH #:**	**12. Work PH #:**	**13. Other Ph #:**

14. Name of Employer:	**15. Part-Time Hire Date:**	**16. Full-Time Hire Date:**	**17. Type of Employment:** ☐ Full-Time ☐ Part-Time: ____ Hours per week

18. LIST ELIGIBLE FAMILY MEMBERS TO BE COVERED (PLEASE PRINT)
A certified copy of the court order must be attached for dependents in court-ordered custody or guardianship of the certificate holder. If more space is required, attach a separate page with additional information. Please provide (on the reverse side of this form) an alternate address for any dependent not living with you.

Applicant's Primary Care Physician Selection: | **Current Patient?** ☐ Yes ☐ No

19. Relationship To You	20. Sex	21. First Name, Middle Initial, & Last Name (if not the same)	22. SSN	23. Date of Birth	24. Disabled	25. Primary Care Physician	26. Current Patient?
Spouse	☐ Male ☐ Female				☐ Yes ☐ No		☐ Yes ☐ No
Dependent 1 ☐ Child ☐ Stepchild ☐ Other ■	☐ Male ☐ Female				☐ Yes ☐ No		☐ Yes ☐ No
Dependent 2 ☐ Child ☐ Stepchild ☐ Other ■	☐ Male ☐ Female				☐ Yes ☐ No		☐ Yes ☐ No
Dependent 3 ☐ Child ☐ Stepchild ☐ Other ■	☐ Male ☐ Female				☐ Yes ☐ No		☐ Yes ☐ No

■ Supporting documentation required.

27. Race/Ethnicity – Optional (This information is designed for the purpose of data collection and will not be used for determining eligibility, rating or claim payment.)

Employee: ☐ African American ☐ American Indian/Native American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other
Spouse: ☐ African American ☐ American Indian/Native American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other
Dependent 1: ☐ African American ☐ American Indian/Native American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other
Dependent 2: ☐ African American ☐ American Indian/Native American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other
Dependent 3: ☐ African American ☐ American Indian/Native American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other

28. Are you or any member of your family covered by any other health plan or health insurance that will be in effect concurrently with the coverage you are applying for? ☐ Yes ☐ No
If yes, complete the appropriate section(s) below. If more space is needed, attach a separate sheet with additional information.

OTHER HEALTH PLAN INSURANCE		**MEDICARE**	
Insured Member's Name:	**Date of Birth:**	**Beneficiary Name:**	**Beneficiary Name:**
Employment Status: ☐ Active ☐ Retired **Type of coverage:** ☐ Single ☐ Family	**Name of Employer:** ____________	**Entitlement Reason:** ☐ Age 65 or Older ☐ End Stage Renal Disease ☐ Other Disability	**Entitlement Reason:** ☐ Age 65 or Older ☐ End Stage Renal Disease ☐ Other Disability
Policy #:	**Effective Date:**	**Medicare #:**	**Medicare #:**
Name of Insurance Company:	**Phone:**	**Part A Effective Date:**	**Part A Effective Date:**
Does the above insurance cover "all" family members including yourself? ☐ Yes ☐ No **If no**, please list dependents not covered on a separate sheet.		**Part B Effective Date:**	**Part B Effective Date:**

29. ACCEPTANCE OF COVERAGE/MEMBERSHIP:
I have read and understand the Acceptance of Any Coverage/Membership on the reverse side of this form.

Signature of Applicant/Employee: Date:

Authorized Group Administrator's Signature:	Group ID:	Date:	Employee's Proposed Coverage Effective Date:

Please return this completed form by:
Mail: Capital Health Plan*Attn: Enrollment*PO Box 15349*Tallahassee FL 32317 **Fax:** 850-523-7369 **OR** **Email:** Enrollment@chp.org