Physicians Plus

Group Enrollment/Change Form

PO Box 269001
Plano, TX 75026-9001

1. Employee Information (Please type or print in ink)

☐ New ☐ Change	Employee (First Name, MI, Last Name)			Social Security #	☐ Single ☐ Married ☐ Divorced
Street Address	City, State	Zip Code	County	Home Phone ( ) Work Phone ( )	E-mail address

2. Family Information and Primary Care Physician (PCP) Selection

Full Name of Members to be Covered	Relationship	Gender (M/F)	Social Security #	Birthdate	PCP Choice: Name/Provider ID/Location (call 608-282-8900 or 800-545-5015 for help)	Enrollment Dept. Use Only	Are you a current patient of this PCP?
Employee	Self						
Spouse	Spouse						
Dependent							
Dependent							
Dependent							

If dependents listed above reside at a different address, please list their name(s) and address(es)

3. Medical Plan Option (Please select your plan type. Consult your employer if multiple plans are offered.)

HMO ☐ Copay ____ ☐ HealthShare ____ ☐ Custom ☐ Regular ☐ Tiered Copay ____ ☐ HSA-Qualified ____ **PPO** ☐ Copay ____ ☐ Tiered Copay ____ ☐ HSA-Qualified ____

POS ☐ Copay ____ ☐ Custom ☐ Regular ☐ Tiered Copay ____ ☐ HSA-Qualified ____

4. Other Health Insurance Information

Do you or any of your dependents receive Workers Compensation Benefits? ☐ YES ☐ No If Yes, please indicate member's name:

Are you or any of your dependents are currently disabled? ☐ YES ☐ No If Yes, please indicate member's name:

When enrolled with Physicians Plus, will you or anyone listed on this application be covered by other health or prescription insurance? ☐ YES ☐ No (If Yes, complete below)

Insurance Company		Address	
Phone	Name of Insured	Dependents Covered	
Policy Effective Date	Group/Policy Number	Employer Name	
List anyone named above who is eligible for Medicare	**Reason** ☐ Over 65 ☐ Kidney Failure ☐ Disability	Specify Medicare Part A, B, C or D and Effective Date	Medicare Number

5. Authorization Signature to Obtain or Release Medical Information

On behalf of myself and my eligible dependents, I hereby agree to the terms and conditions of enrollment and to the Authorization to Obtain or Release Medical Information which appears above and on the reverse side of this application.

Employee Signature: Date Spouse/Partner Signature (if applicable) Date

6. For Employer Use Only

Date of Hire	Effective Date	Is the employee currently working? ☐ YES ☐ NO	Hours Worked per week	Group/Division #
☐ New Hire ☐ New Group ☐ Loss of Coverage ☐ Family Status Change ☐ Late Entrant ☐ Annual Multi Carrier ☐ Cancel All Coverage ☐ Other		Describe Special Enrollment & attach documentation:	Date of Special Enrollment	Effective Date of Change

Reason for Change: ☐ Elect Continuation/COBRA ☐ Add Dependents listed above ☐ Delete dependents listed above ☐ Other

Name of Employer	E-mail Address	Phone	Approved by	Date

White & Yellow Copies: Physicians Plus **Pink Copy:** Applicant