



Health Plan Effective Date: _____

Select one health plan and one coverage level:

- BCO PPO - Employee Employee +1 Family
 HMO - Employee Employee+1 Family
 HSA - Employee Family

*If choosing HMO – see below for additional information needed

Are you or any dependents covered by Medicare? Y N – If yes, see HRM for additional information needed.

Dental Plan Effective Date: _____

Select one health plan and one coverage level:

- PPO1 - Employee Employee+1 Family
 PPO2 - Employee Employee+1 Family
 PPO3 - Employee Employee+1 Family

Vision Plan Effective Date: _____

Select one:

- Employee
 Family

I APPLY FOR COVERAGE AS INDICATED ABOVE – I have completed the above form and attest that all of the information provided is true and complete to the best of my knowledge. I understand that I am required to furnish proof of relationship for dependents added to the insurance coverage (marriage certificate, divorce decree, court documents establishing guardianship or adoption and/or the birth certificate for any individual for whom I seek benefits).

Signature of Applicant

Date Signed

HRM Use Only

Dependent Verification Type:



*For HMO Participants:

Employee: _____

Medical Group/IPA#: _____ Medical Group/IPA Name: _____

WPHCP Medical Group/IPA#: _____ WPHCP (Medical Group Name): _____

Are you already a patient? Yes No

Dependent Name: _____

Medical Group/IPA#: _____ Medical Group/IPA Name: _____

WPHCP Medical Group/IPA#: _____ WPHCP (Medical Group Name): _____

Are you already a patient? Yes No

Dependent Name: _____

Medical Group/IPA#: _____ Medical Group/IPA Name: _____

WPHCP Medical Group/IPA#: _____ WPHCP (Medical Group Name): _____

Are you already a patient? Yes No

Dependent Name: _____

Medical Group/IPA#: _____ Medical Group/IPA Name: _____

WPHCP Medical Group/IPA#: _____ WPHCP (Medical Group Name): _____

Are you already a patient? Yes No

Dependent Name: _____

Medical Group/IPA#: _____ Medical Group/IPA Name: _____

WPHCP Medical Group/IPA#: _____ WPHCP (Medical Group Name): _____

Are you already a patient? Yes No

Dependent Name: _____

Medical Group/IPA#: _____ Medical Group/IPA Name: _____

WPHCP Medical Group/IPA#: _____ WPHCP (Medical Group Name): _____

Are you already a patient? Yes No