





Health Plan Effective Date: \_\_\_\_\_

**Select one health plan and one coverage level:**

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

\*If choosing HMO – see below for additional information needed

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**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

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*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