# ROSE AND KIERNAN, INC. ENROLLMENT APPLICATION

**EMPLOYER USE ONLY**

Group Name

Group No. | Employee Code

Effective Date Requested ____/____/____

**TRUST USE ONLY**

| Employee No. | Billing Class | Group Code |
|---|---|---|
| | | |

## SECTION 1

Your Last Name ______ First ______ M.I. ______

Address ______

City ______ State ______ Zip Code ______

Your Social Security No. ☐☐☐ ☐☐ ☐☐☐☐

❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Date of Marriage ____/____/____ Date of Divorce ____/____/____

Phone No.: (______)______ (______)______

Employment Status: ❑ Full-time ❑ Part-time ❑ Active ❑ Retired ❑ COBRA

Date of Employment ____/____/____ Date of Retirement ____/____/____

## SECTION 2

❑ New Enrollment/Reinstatement (complete Section 4)

❑ Change Coverage to: (check new coverage)

❑ Cancel Coverage: (check those that apply)

❑ Add or Delete Dependent: (complete Section 4)

❑ Change Enrollee's Information: (complete Section 1 with new information)

**REASON:** ______

| TYPE | PLAN | IND | 2-PER | FAM | MDCR |
|---|---|---|---|---|---|
| Traditional | | ❑ | ❑ | ❑ | ❑ |
| PPO | | ❑ | ❑ | ❑ | ❑ |
| POS | | ❑ | ❑ | ❑ | ❑ |
| HMO | PCP Copay: ☐ Specialist Copay: ☐ | ❑ | ❑ | ❑ | ❑ |
| Drugs | | ❑ | ❑ | ❑ | ❑ |
| Dental | | ❑ | ❑ | ❑ | ❑ |
| Vision | | ❑ | ❑ | ❑ | ❑ |

## SECTION 3

### OTHER COVERAGE?

Is there coverage under any other group health plan available to you or any member of your family?
❑ No ❑ Yes

If Yes; Policyholder Name ______ Relationship ❑ Self ❑ Spouse ❑ Child

Social Security Number ______ Birthdate ____/____/____

Insurance Co. Name ______ Policy # ______

Address ______

**Plan Type** ❑ Self Only ❑ Self and Family **Coverage Type** ❑ Health ❑ Drug ❑ Dental ❑ Vision

## SECTION 4

### LIST APPLICANT AND ALL ELIGIBLE DEPENDENTS

Copy of medical card required

### HMO OR POS ENROLLMENT

| ADD | DELETE | Relationship | NAME Last | First | M.I. | Birthdate (mo/day/yr) | Full-Time Student | Social Security # | Medicare A & B Effective Date | Medical Practice Number | Primary Care Physician – OB/GYN | Existing Patient ✓ |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ❑ | ❑ | **Self** ❑ M ❑ F | | | | ___/___/___ | | ___–___–___ | ___/___/___<br>___/___/___ | | PCP<br>OB/GYN | |
| ❑ | ❑ | ❑ Husband<br>❑ Wife | | | | ___/___/___ | | ___–___–___ | ___/___/___<br>___/___/___ | | PCP<br>OB/GYN | |
| ❑ | ❑ | ❑ Son<br>❑ Daughter | | | | ___/___/___ | ❑ Yes<br>❑ No | ___–___–___ | ___/___/___<br>___/___/___ | | PCP<br>OB/GYN | |
| ❑ | ❑ | ❑ Son<br>❑ Daughter | | | | ___/___/___ | ❑ Yes<br>❑ No | ___–___–___ | ___/___/___<br>___/___/___ | | PCP<br>OB/GYN | |
| ❑ | ❑ | ❑ Son<br>❑ Daughter | | | | ___/___/___ | ❑ Yes<br>❑ No | ___–___–___ | ___/___/___<br>___/___/___ | | PCP<br>OB/GYN | |
| ❑ | ❑ | ❑ Son<br>❑ Daughter | | | | ___/___/___ | ❑ Yes<br>❑ No | ___–___–___ | ___/___/___<br>___/___/___ | | PCP<br>OB/GYN | |

## SECT. 5

Do your dependents reside in your home?
❑ Yes ❑ No If No give address:

Do you have a disabled dependent beyond age 19?
❑ No ❑ Yes List name(s):

Full-time college students age 19 and over:

| List names | School Name and Address | Expected Graduation: |
|---|---|---|
| | | |
| | | |
| | | |

**AGREEMENT: I HAVE READ AND AGREE TO THE AUTHORIZATION ON THE REVERSE SIDE OF THIS FORM.**

Applicant's Signature ______ Date ______

Adult Dependent Signature ______ Date ______

Adult Dependent Signature ______ Date ______

Adult Dependent Signature ______ Date ______

Employer's Signature ______

Date ____/____/____

RETURN TOP THREE COPIES TO ROSE AND KIERNAN, INC. Pink Copy – EMPLOYER Gold Copy – EMPLOYEE

Form 0702