

Access Health Inc. ENROLLMENT, DENIAL, TERMINATION & CHANGE FORM

__ C3 __ NON

- Employee Enrollment C3
 Termination of Coverage*
 Addition of Dependents
 Physician Change
 Employee Enrollment STD
 Address Change
 Card Replacement
 Decline coverage*

A. Complete & Return form by the 5th: 1200 Ransom, Suite 102, Muskegon, MI 49442 or fax (231) 728-5160

Name of Employer			Employer Address (Street, City, State, Zip Code)		
Employee's Occupation/location: Date of Permanent Hire:			<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input checked="" type="checkbox"/> Widowed		
Employee Last Name	First Legal Name	Initial	Home Address (Street, City, State, Zip Code)		
Phone: Home	Phone: Work		Email:		
Complete for all family members		Social Security Number (record only)	Date of Birth	Sex	MI * Child
First Name	Initial	Last Name	All children must have a Medicaid denial or certificate of credible coverage		
Employee					<input type="checkbox"/> I currently do <u>not</u> have ANY health Coverage.
Spouse					<input type="checkbox"/> I currently do <u>not</u> have ANY health Coverage.
Dependents					<input type="checkbox"/> I currently do <u>not</u> have ANY health Coverage.
					<input type="checkbox"/> I currently do <u>not</u> have ANY health Coverage.
					<input type="checkbox"/> I currently do <u>not</u> have ANY health Coverage.

* Designate if child is on MI Child/Healthy Kids programs. Attach Medicaid Denial or Certificate of Credible Coverage.

PRIMARY CARE PHYSICIAN-VERIFY W/ THEIR OFC IF YOU HAVE CHOSEN A NEW PCP	Effective Date if new
Employee's Physician Name:	
Spouse's Physician Name:	
Dependent's Physician Name:	
Dependent's Physician Name:	

(Required) List the most recent or current health coverage: (INCLUDES MEDICAID, MUSKEGON CARE OR OTHER HEALTH COVERAGE)

Name: (s)	Previous or Current Coverage	End Date	Comments:

I hereby represent and agree that all statements in this request are full, complete and true, to the best of my knowledge and understand that the said statements form the basis upon which coverage will be made effective. I understand that omissions, misrepresentations or misstatements could result in the denial of an otherwise valid claim rescission, voiding, reformation or termination of coverage subject to the time limit on certain defense provisions set forth in the Policy. I understand explanation of the coverage as stated in the Handbook. I agree that my AH membership may be cancelled if I do not comply with my obligations as stated in the Handbook. My signature on this form authorizes all medical records, to be released to Access Health, Inc. for the period of eligibility for the enrolled members. I have received and read the Access Health Benefit Handbook.

(EMPLOYEE SIGNATURE FOR ENROLLMENT or DENIAL)	(DATE)
(EMPLOYER SIGNATURE FOR ENROLLMENT)	(DATE)

B.Termination/Denial- employer signature is required

- Other healthcare coverage
 Resigning Employment
 Declining Coverage
 AH Initiated
 Terminated by Employer
 Promotion
 Other Reason/List _____

Employee: I am terminating my coverage: _____
EMPLOYEE SIGNATURE DATE

Employer: I am terminating above employee's coverage for above listed reason: _____
EMPLOYER SIGNATURE DATE

AH Office Use: Received: _____ Effective Date: _____ **** Due by the 5th of the previous month****
****THE ENROLLMENT OR TERMINATION DATE IS DETERMINED BY THE DATE THE FORM IS REVIEWED BY ACCESS HEALTH****