ENROLLMENT & CHANGE FORM

Underwritten by: **NATIONAL HEALTH INSURANCE COMPANY**
Third Party Administrator: Meritain
1405 Xenium Lane North, Suite 140, Minneapolis, MN 55441
800-847-8361
Fax Enrollment/Change Form to: (763)852-5011
Visit our website for more information at: www.meritain.com

Name of Employer _____

Group Number _____ **Effective Date/Date of Change** _____

PPO elected _____ **Aetna** _____

Check Reason for Enrollment or Change

- ☐ Address Change
- ☐ Special Enrollment
- ☐ Waiver of Insurance Election
- ☐ Open Enrollment
- ☐ New Subscriber
- ☐ Group Transfer
- ☐ COBRA
- ☐ Change Name
- ☐ Cancel
- ☐ Add a Family Member

Date _____

Cancellation Reason _____

Add a Family Member Reason _____

Terminate a Family Member Reason _____

Other Reason _____

EMPLOYEE INFORMATION

Last Name	Legal First Name	Nickname	Middle Initial	Status
				☐ Single ☐ Married ☐ Domestic Partner
Home Address (Including mailing address if different)				
City	State	Zip	County	Date of Full-Time Employment_____
Home Telephone ( )	Work Telephone ( )			

EMPLOYEE AND DEPENDENT(S) INFORMATION

NAME (First, MI, Last) (Social Security Number required for processing) (child must be under age 26 unless disabled)	Date of Birth MM/DD/YY	Relationship to Subscriber	Sex M/F
1. Employee Name SSN#	/ /		
2. Name of Spouse/Domestic Partner SSN#	/ /		
3. Dependent Name SSN#	/ /	☐ Child ☐ Grandchild ☐ Stepchild ☐Guardianship	
4. Dependent Name SSN#	/ /	☐ Child ☐ Grandchild ☐ Stepchild ☐Guardianship	
5. Dependent Name SSN#	/ /	☐ Child ☐ Grandchild ☐ Stepchild ☐Guardianship	
6. Dependent Name SSN#	/ /	☐ Child ☐ Grandchild ☐ Stepchild ☐Guardianship	

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OTHER INSURANCE COVERAGE INFORMATION

1. Will you or your dependents continue to be covered under another health insurance plan while you are covered under this plan?

☐ Yes ☐ No If yes, answer the following:

Who will continue to be covered: ☐ Self ☐ Spouse/Domestic Partner ☐ Child(ren)

Effective date of the policy ____/____/____ Type of Plan: ☐ Group ☐ Individual ☐ Other
month day year

Name of insurance company _____ Telephone Number (____) _____

Is this plan through your spouse's employer? ☐ Yes ☐ No If yes, provide the following:

Name of employer _____ Telephone number (____) _____

2. Do you or your Dependents currently have Medicare coverage? ☐ Yes ☐ No If yes, answer the following:

Name of person covered by Medicare _____ Medicare claim number _____

Is Medicare eligibility due to? ☐ Over age 65 ☐ End-stage renal disease ☐ Total disability

Part A effective date ____/____/____ Part B effective date ____/____/____
month day year month day year

Part C effective date ____/____/____ Part D effective date ____/____/____
month day year month day year

DISCLOSURES, AUTHORIZATION AND SIGNATURE

I have answered the above questions to the best of my knowledge and belief. I understand and agree that no coverage shall be in force until: eligibility requirements have been met, and a certificate of insurance is issued, which shall not be valid unless the first premium is paid.

Signature of Applicant _____ **Date Signed** _____

Underwriter completes	
Underwriter	Approved Date