

Please use a ball point pen and press down firmly.

Application for Enrollment

- New employee
- Annual enrollment
- COBRA Continuation
- Involuntary loss of prior group coverage*
- Other _____

*Documentation required

Change in Enrollment

- Add dependents
- Remove dependents
- PCP/Site change
- Termination
- Employee/dependent demographics
- Other _____

Reason for Change in Enrollment

- Marriage
- Birth of child
- Adoption of child*
- Divorce
- Left employment
- Reached age 65
- Add disabled dependents
- Moved out of service area
- Voluntary
- Loss of dependent eligibility
- Death, exact date _____

Group Information

AllWays Health Partners group number				Employer name				
Date of employment	Month	Day	Year	Effective Date	Month	Day	Year	Plan design

Intermediary

- Group
- Non-group

Employee Information

Last name				First name				M.I.
Date of birth (mm/dd/yy)	Social Security Number			Gender (m/f)	Home phone – Include area code			Email address
Street mailing address			Apt.	P.O. Box	City		State	Zip code

For help finding a PCP in our network, please go to alwayshealthpartners.org and search our Find a Doctor tool. You may change your PCP at any time.

PCP and Site Information

Primary care site	
Your Primary Care Physician (Last name, First, M.I.)	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

Language

What language do you speak most often? Please check (✓) the appropriate box. Knowing the main language spoken by you and your family members will help us to better serve your needs.

English Spanish Cantonese Cape Verdean Creole French Haitian Creole Mandarin Portuguese Russian Vietnamese Other, please specify _____

Group Coverage

Type of AllWays Health Partners coverage (check only one)		In addition to AllWays Health Partners, my spouse or children are covered by a health plan offered by:					
<input type="checkbox"/> Self	<input type="checkbox"/> Individual & spouse	<input type="checkbox"/> Individual & child/children	<input type="checkbox"/> Family	Employer	Insurance co. name	Policy #	Effective date
Are you and/or your spouse eligible for Medicare?	Self	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, are you enrolled in		<input type="checkbox"/> Medicare Part A	<input type="checkbox"/> Medicare Part B	Your Medicare policy number
	Spouse	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, is your spouse enrolled in		<input type="checkbox"/> Medicare Part A	<input type="checkbox"/> Medicare Part B	Your spouse's Medicare policy number

Please provide **ALL** information below for any eligible dependents you wish to enroll.

Spouse last name		First name		M.I.	Primary care site	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of birth	Social Security Number		Gender (m/f)	Other Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary care physician (last name, first name, M.I.)	
Dependent last name		First name		M.I.	Primary care site	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of birth	Social Security Number		Gender (m/f)	Other Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary care physician (last name, first name, M.I.)	
Dependent last name		First name		M.I.	Primary care site	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of birth	Social Security Number		Gender (m/f)	Other Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary care physician (last name, first name, M.I.)	
Dependent last name		First name		M.I.	Primary care site	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of birth	Social Security Number		Gender (m/f)	Other Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary care physician (last name, first name, M.I.)	
Dependent last name		First name		M.I.	Primary care site	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of birth	Social Security Number		Gender (m/f)	Other Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary care physician (last name, first name, M.I.)	

Acknowledgement: The information supplied on this form is true and complete. I assign benefits to AllWays Health Partners for the cost of services when the liability for payment is the responsibility of another plan/HMO, worker's compensation plan or other coverage. I (we) agree that AllWays Health Partners and its affiliated health care providers may obtain or release my (our) medical information including medical records, medical coverage available or other medical data for the purposes of administering benefits, evaluating medical care provided, conducting quality assurance reviews and analysis, conducting medical research, and/or as required by law. I (we) understand that for AllWays Health Partners coverage to be in effect when medical care supplies are obtained, all care and supplies must be authorized and provided by participating care physicians (as listed above).

Acuerdo: La información proporcionada en esta forma es veraz y completa. Asigno (asignamos) beneficios a AllWays Health Partners por el costo de servicios cuando la responsabilidad del pago sea de otro plan de salud/HMO, plan de compensación para trabajadores o otro tipo de cobertura. Estoy (estamos) de acuerdo que AllWays Health Partners y sus Proveedores de Cuidado de Salud afiliados pueden obtener o divulgar mi (nuestra) información médica, incluyendo registros médicos, cobertura médica disponible o otra información médica, con el propósito de administrar beneficios, evaluar la atención médica proporcionada, realizar revisiones y análisis de control de calidad, realizar investigaciones médica y/o cuando es requerida por la ley. Yo entiendo (entendemos) que para que la cobertura de AllWays Health Partners tenga vigencia para la obtención de suministros médicos, toda la atención y todos los suministros deben ser autorizados y proporcionados por un medico de cuidado primario participante autorizado (segun se indica arriba).

All information must be completed and form signed before processing can begin

Employee's signature: _____ Date: _____

Employer contact