ENROLLMENT APPLICATION

MEDICAL ASSOCIATES
HEALTH PLANS®
1605 Associates Drive
Dubuque, Iowa 52002
(563) 584-4885 or Toll Free 1-866-821-1365
E-mail: memberservices@mahealthcare.com

COMMUNITY Plan

PRESS HARD
YOU ARE MAKING 3 COPIES

Effective Date of Enrollment _____

Division Number _____

☐ NEW ENROLLMENT or
☐ CHANGE NOTICE

- ❒ Changing PCP (list name of dependent & physician changing to in Section B)
- ❒ Add dependents-list dependent(s) to add in Section B
- ❒ Remove dependents-list dependent(s) to remove in Section B
- ❒ Reason for adding or deleting members _____
- ❒ Effective Date of Change_____
- ❒ Cancel Coverage Effective_____
- ❒ Change Name from _____ (list new name in Section A or B)
- ❒ Change of Address_____ (list new address in Section A)
- ❒ Other (specify)_____
- ❒ Effective Date_____

CHANGE COVERAGE TO:

- ❒ Single
- ❒ Employee + Spouse
- ❒ Employee + Child
- ❒ Employee + Children
- ❒ Family

THIS APPLICATION MUST BE COMPLETED IN FULL FOR ALL NEW ENROLLMENTS

Number of cards needed _____
You will automatically receive two ID cards

SECTION A: SUBSCRIBER DATA

EMPLOYER NAME	DATE EMPLOYED	EMPLOYEE #

LAST NAME	MAIDEN NAME	FIRST NAME	INITIAL	MARITAL STATUS	SEX

STREET ADDRESS	CITY	STATE	ZIP
			_____ - _____

COUNTY	SOCIAL SECURITY NO.	PHONE NUMBER	DATE OF BIRTH	PRIMARY CARE PHYSICIAN(PCP)
		( )	_____/_____/_____	

DOES THIS POLICY REPLACE ANY OTHER GROUP HEALTH POLICY? ❒ YES ❒ NO	IF YES, WHAT IS THE NAME OF THE INSURANCE COMPANY?

SECTION B: SPOUSE/DEPENDENT DATA

NAME (Last, First, Middle Initial)	PRIMARY CARE PHYSICIAN(PCP) See provider directory for complete listing	DATE OF BIRTH	SEX	FULL-TIME STUDENT?	SOCIAL SECURITY NUMBER
SPOUSE					
DEPENDENT					
DEPENDENT					
DEPENDENT					
DEPENDENT					
DEPENDENT					

SECTION C: COORDINATION OF BENEFITS

IS YOUR SPOUSE EMPLOYED?
❒ YES ❒ NO

IS YOUR SPOUSE COVERED UNDER A GROUP HEALTH POLICY WITH THAT EMPLOYER ❒ YES ❒ NO	ARE YOU AND/OR ANY DEPENDENT CHILDREN ALSO COVERED UNDER YOUR SPOUSE'S POLICY? ❒ YES ❒ NO

IF "YES" TO THE ABOVE QUESTION, WHAT IS THE NAME OF THE INSURANCE COMPANY, AND LIST FIRST NAMES OF ALL PERSONS COVERED (if there is a court-ordered document, please send a copy):	ARE ANY OF THE FOLLOWING ELIGIBLE FOR MEDICARE? ❒ SELF ❒ SPOUSE ❒ DEPENDENT

I hereby authorize the release of my and/or my dependents medical records and claims for all medical services, to Medical Associates Health Plans staff or its designated agents and agree to abide by the provisions and regulations as set forth by the subscriber agreement for which I have enrolled.

Signature _____ **Date** _____