

EMPLOYEE DETAILS

First Name	<input type="text"/>	Last Name	<input type="text"/>
Member ID	<input type="text"/>	Hours worked per week	<input type="text"/>
Email Address	<input type="text"/>	Phone No	<input type="text"/>
Current Coverage Tier	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee & Spouse	<input type="checkbox"/> Employee & Child(ren) <input type="checkbox"/> Family
Requested Coverage Tier	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee & Spouse	<input type="checkbox"/> Employee & Child(ren) <input type="checkbox"/> Family

PLAN SECTIONS

Current Medical plan	<input type="checkbox"/> SHIC	<input type="checkbox"/> SP1000	<input type="checkbox"/> SP2500	<input type="checkbox"/> MM10	<input type="checkbox"/> MM20	<input type="checkbox"/> MM30
Requested Medical plan	<input type="checkbox"/> SHIC	<input type="checkbox"/> SP1000	<input type="checkbox"/> SP2500	<input type="checkbox"/> MM10	<input type="checkbox"/> MM20	<input type="checkbox"/> MM30
Current Dental plan	<input type="checkbox"/> D1k	<input type="checkbox"/> D2k	<input type="checkbox"/> D3k			
Requested Dental Plan	<input type="checkbox"/> D1k	<input type="checkbox"/> D2k	<input type="checkbox"/> D3k			
Current Vision Plan	<input type="checkbox"/> V250	<input type="checkbox"/> V500				
Requested Vision Plan	<input type="checkbox"/> V250	<input type="checkbox"/> V500				
Requested date of change if not in open enrollment period	<input type="text"/>					

DEPENDENT DETAILS (IF ENROLLING IN COVERAGE)

First Name	Last Name	Date of Birth MM/DD/YY	Gender M/F	Relationship S-Spouse,C-Child	Add	Remove

MEDICAL QUESTIONS (ANSWER ALL QUESTIONS)

Have you or a dependent been diagnosed with a new medical condition within the past 12 months? Yes No

If Yes, please state the condition(s)

Have you or a dependent been requested to have a future medical procedure? Yes No

If Yes, please state the medical procedure

Have you been prescribed medication within the past 12 months? Yes No

If Yes, please provide the name(s) of the medication(s)

Are you currently pregnant? Yes No

If Yes, please provide your due date

OTHER COVERAGE

Is your spouse employed? Yes No If Yes, Name of Employer

Do you or any dependents have any other health insurance coverage? Yes No

If Yes, who is the primary insured?

Name of other insurance company

- (a) I hereby declare that the answers given and recorded herein are to the best of my / our knowledge, complete and true as at this date.
(b) I understand and agree that coverage shall not become effective until accepted by the approved insurer.
(c) I understand that this application will be valid for 30 days after the date of the signature.
(d) I understand that falsifying information on this document may result in the restriction or revocation of coverage.

For further information on how we will use your personal data, please see www.onehealth.ky

Employee Signature

Date