ONC HEALTH PLAN

Membership Application

ALL INFORMATION MUST BE PROVIDED. PLEASE TYPE OR PRINT IN INK.

___New Enrollment **___Change of Enrollment** **___Remove Enrollment**

Group Enrollment Card

Employer: _____ SS#: _____

Employee

Name: _____

(Last) (First) (Middle)

Home Address: _____

City: _____ State: _____ Zip: _____

Birth Date: _____ Sex: Male Female

Home Telephone: ( ) _____

Business Telephone: ( ) _____

IMPORTANT

Are you covered under another HEALTH INSURANCE?

Yes No

If Yes:

Co. Name: _____

Address: _____

_____

Eff. Date of Coverage: _____

Family Single

(Circle Type of Coverage)

Circle desired coverage type (All that apply):

Plan U Plan D Plan L COBRA Over 65 Ind. Family

Marital Status: Married Single Divorced Widowed Separated Date of Marriage: _____ Date of Divorce: _____

Spouse's Name: _____ SS#: _____ Date of Birth: _____

Employer: _____ Other Medical Ins.: Yes No If yes, Name of Insurance Carrier: _____

Dependent List: Name	SS#	Birth Date	Relation	If Full Time Student – Over 19: Name and Address of School / Date of Graduation	Handi-capped Yes/No	Other Medical Insurance Yes/No
1.						
2.						
3.						
4.						
5.						

If any dependent is covered under other medical insurance, you MUST complete this section:

Dependent Name Ins. Co. Name Address Eff. Date of Coverage Coverage Type (Family or Single)

1. _____

2. _____

3. _____

Enrollee Statement: I swear the above information is true and correct and all my health insurance coverage has been indicated for myself and my dependents.

_____ _____

Signature Date

Employee Declination Statement – IRC 89

I swear that I have been advised of the availability of the medical benefits available to me. Further, I chose not to participate in these programs at this time.

_____ _____

Signature Date

Employer Statement: Work Status - __Full-time __Part-time __On Leave __Retired __COBRA

Date of Employment: _____ Effective Date: _____ Termination Date: _____

Employer Representative: _____ Date: _____