WESTERN MICHIGAN HEALTH INSURANCE POOL (WMHIP)

Name of Employer/Plan Sponsor: **WMHIP –** Forest Hills Public Schools	**Priority Health**	________ **POS 100%** ________ **$1250/$2500 HSA** ________ **POS 90%**	
Check One: ☐ **Initial**	☐ **Change**	☐ **Termination**	☐ **Reinstatement**
Reason for Change (check all that apply): ________ Initial Eligibility Following Hire ________ Open Enrollment ________ Status Change: ________________ ________ Other: ______________________	**Group:** _____ **Bus Drivers** _____ **Admin/ Supervisors** ____ **Support Staff**	**Date of Hire:** **Hours Worked Weekly:**	**Effective Date of Coverage or Change:**

Employee Information

Employee Name (last, first, middle initial):	☐ Female ☐ Male	Date of Birth:	Social Security Number:	Salary:
Street Address:		Telephone (including area code): Work: ____________________ Home: ____________________		
City:	State:	ZIP Code:		

Do you have other insurance through your spouse? ☐ Yes ☐ No	If Yes, Spouse's Employer:	Name of Insurance Carrier: ______________________ ☐ Medical ☐ Dental ☐ Vision	Plan Number:	Type of Coverage: ☐ Single ☐ Family
Does any proposed insured have other medical coverage? ☐ Yes ☐ No		Name of Insurance Carrier:	Plan Number:	Effective Date: __________ End Date: ______________
Are you or any of your dependents eligible for Medicare benefits? ☐ Yes Name: ____________________________ ☐ No		Is any proposed insured currently covered under COBRA? ☐ Yes Effective Date: ______________________ ☐ No		

If coverage for a child or children is mandated by divorce decree or paternity order, please submit a copy of the decree or order with this form.
Who is responsible for coverage of child(ren) listed? ☐ Mother ☐ Father ☐ Both ☐ Other
Who has physical custody? ☐ Mother ☐ Father ☐ Other

Dependent's Name	Relationship to Child	Birth Date	Social Security Number	Sex	Termination Date
Spouse:				☐ Female ☐ Male	
Child:	☐ Natural ☐ Step			☐ Female ☐ Male	
Child:	☐ Natural ☐ Step			☐ Female ☐ Male	
Child:	☐ Natural ☐ Step			☐ Female ☐ Male	

EMPLOYEE CERTIFICATION AND SIGNATURE

- To the best of my knowledge and belief, the information I have provided on this form is correct. I hereby certify that the dependents listed above are my dependents within the definition contained in the group Plan of my employer. I agree to notify the Plan Administrator if and when there is a change in any dependent's status.
- The current benefits have been explained to me thoroughly. I hereby request coverage as outlined above under the Plan offered by my employer for which I am or may become eligible, and I authorize my employer to deduct any required contribution from my earnings. I reserve the right to revoke this authorization at any time upon written notice.
- **I understand that any person who knowingly and with intent to defraud submits an application or files a claim containing any materially false or misleading information commits a fraudulent act, which is a crime.**
- I understand that in the event of any discrepancy between this enrollment form and any policy in which I am enrolling, the terms of the policy shall apply.
- I understand my coverage begins on the effective date assigned by the Administrator, provided I have met all eligibility requirements.

EMPLOYEE SIGNATURE: ____ DATE: ________________________