



## EMPLOYEE ENROLLMENT FORM FOR GROUP COMPREHENSIVE HEALTH INSURANCE

<b><i>Employer Information</i></b>				
Name of Employer				
<b><i>Applicant Information</i></b>				
First Name		Middle Name		Last Name
Date of Birth (mm/dd/yyyy)		Social Security Number		Gender [ ] Male [ ] Female
Mailing Address		City		State Zip Code
Primary Phone Number		Secondary Phone Number		Email Address
<b>Race (Optional)</b> <div style="display: flex; justify-content: space-between;"> <div style="width: 48%;"> <input type="checkbox"/> American Indian or Alaskan Native  <input type="checkbox"/> Asian or Pacific Islander  <input type="checkbox"/> Asian Pacific American  <input type="checkbox"/> Black  <input type="checkbox"/> Black ( Non-Hispanic)  <input type="checkbox"/> Caucasian  <input type="checkbox"/> Hispanic </div> <div style="width: 48%;"> <input type="checkbox"/> Mutually Defined  <input type="checkbox"/> Native American  <input type="checkbox"/> Native Hawaiian  <input type="checkbox"/> Other Race or Ethnicity  <input type="checkbox"/> Pacific Islander  <input type="checkbox"/> Subcontinent Asian American  <input type="checkbox"/> White ( Non-Hispanic ) </div> </div>				
<b><i>Waiver of Coverage - You must complete this section if you DO NOT want coverage.</i></b>				
<input type="checkbox"/> I am declining coverage due to the existence of other coverage: <input type="checkbox"/> Group Plan <input type="checkbox"/> Individual Plan <input type="checkbox"/> Tri-Care <input type="checkbox"/> Medicaid <input type="checkbox"/> Continuation/COBRA <input type="checkbox"/> Medicare <input type="checkbox"/> VA Eligible <input type="checkbox"/> Children's Health Insurance Program <input type="checkbox"/> I (and/or family members) choose to be without coverage.				
<b><i>Acceptance of Coverage</i></b>				
[ ] I wish to enroll for this group coverage.				
Benefit Plan Selection:				
[ ] Plan A Platinum				
[ ] Plan B Silver				
<b><i>Dependents to be insured (Indicate all dependents to be insured under the Group Policy.)</i></b>				
First Name		Last Name		Date of Birth Gender [ ] Male [ ] Female

Social Security Number	Relationship to Applicant [ ] Spouse [ ] Domestic Partner [ ] Dependent Child		
First Name	Last Name	Date of Birth	Gender [ ] Male [ ] Female
Social Security Number	Relationship to Applicant Dependent Child		
First Name	Last Name	Date of Birth	Gender [ ] Male [ ] Female
Social Security Number	Relationship to Applicant Dependent Child		
First Name	Last Name	Date of Birth	Gender [ ] Male [ ] Female
Social Security Number	Relationship to Applicant Dependent Child		
First Name	Last Name	Date of Birth	Gender [ ] Male [ ] Female
<i>Has any person to be covered, who may legally use tobacco under feral or state law, used any tobacco product on an average of four or more times per week within the past 6 months (this does not include tobacco use for religious or ceremonial use)?</i> [ ] Yes [ ] No If "Yes", please provide information below			
Name	Currently Using Tobacco Product (s) (Y/N)	Type of Tobacco Product Used	Willing to participate in a cessation program? (Y/N)

To the best of my knowledge and belief, the information I have provided on this form is correct and complete. I understand that false or inaccurate information may result in the termination of coverage or the nonpayment of benefits. I understand that premiums for my coverage under the group policy will be remitted to the Montana Health Cooperative by my employer. If I must contribute to the premium for my coverage, I understand that arrangements for payroll deduction will be made by my Employer.

**Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison and may result in denial of coverage under the Group Policy.**

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date signed