# VIRGINIA APPLICATION

MAMSI Life and Health Insurance Company
A UnitedHealthcare Company

P.O. Box 942, Frederick, MD 21705-0941

☐ COBRA
First Date on COBRA _____

☐ New Enrollment
☐ Dependent Addition
☐ Re-enrollment
☐ Disenroll
☐ Address Change
☐ Conversion
☐ Name Change

## A. Other Insurance Information

Do you or any MLH family member have other health insurance that will be in effect at the same time as your MLH policy? ☐ Yes ☐ No

Health Insurance Company

Phone Number | Policy Number

In the past seven years, have you or any family member been treated for injuries from an accident? ☐ Yes ☐ No

Are you or any MLH family member covered by Medicare? ☐ Yes ☐ No
If yes, Medicare number: _____

## B. Member Information

| Social Security Number | Group Policy Number | Effective Date | Member Number |
|---|---|---|---|
| ___-___-___ | | | |

| Name (Last) (First) (MI) | Street Address or P.O. Box Number |
|---|---|
| Birth Date / Sex / Previous Membership in MLH? ☐ Yes ☐ No | City / State / ZIP Code |
| Home Phone ( ) / E-Mail Address | Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated / If adding a spouse, please give date of marriage: |
| Name of Employer / Date Employed | Business Phone ( ) |

## C. Dependent Information

***Note: All unmarried children ages 19-23 must be full-time students or permanently disabled to be eligible for coverage. (Attach additional sheets if needed.)***

| | | | | | |
|---|---|---|---|---|---|
| 02 | Spouse's Name (Last) (First) (MI) | Date of Birth | Social Security Number ___-___-___ | Disabled? ☐ Yes ☐ No | Sex ☐ Male ☐ Female |
| 03 | First Eligible Child's Name (Last) (First) (MI) | Date of Birth | Sex ☐ Male ☐ Female | Social Security Number ___-___-___ | Student Over 18? ☐ Yes ☐ No / Disabled? ☐ Yes ☐ No |
| 04 | Second Eligible Child's Name (Last) (First) (MI) | Date of Birth | Sex ☐ Male ☐ Female | Social Security Number ___-___-___ | Student Over 18? ☐ Yes ☐ No / Disabled? ☐ Yes ☐ No |
| 05 | Third Eligible Child's Name (Last) (First) (MI) | Date of Birth | Sex ☐ Male ☐ Female | Social Security Number ___-___-___ | Student Over 18? ☐ Yes ☐ No / Disabled? ☐ Yes ☐ No |

**If enrolling a newborn: Date of discharge from Hospital:** _____ **Was this later than the mother's discharge date?** ☐ Yes ☐ No

## D. Employee and/or Dependent Removal from Health Plan

| | | | | | |
|---|---|---|---|---|---|
| Employee's Name (Last) (First) (MI) | Last Day of Coverage | 01 | Reason Code | Enter reason code(s) in box(es) at left: 1. Changed employment 2. Deceased 3. Dissatisfied 4. No longer eligible 5. Other insurance |
| Spouse's Name (Last) (First) (MI) | Last Day of Coverage | 02 | Reason Code | |
| Child's Name (Last) (First) (MI) | Last Day of Coverage | 03 | Reason Code | |

## E. Conditions of Enrollment

**If you have any questions concerning the benefits and services provided by or excluded under this agreement, please contact a Member Services Representative before signing this application.**

I hereby apply for membership in the Health Plan for myself and any listed dependents. I have read this application in its entirety, including the Approval to Collect and Disclose Health Information and Enrollment Certifications statement on the other side of this application.

By my signature below, I represent that I understand and agree to all terms and conditions stated in this application, and that all information given by me is accurate, current and complete to the best of my knowledge and belief.

Signature of Member or Member's representative | Date

Printed name of Member or Member's representative: _____

Member representative's relationship to the Member and statement of the representative's capacity:

Group Authorization | Date

MAMSI LIFE AND HEALTH INSURANCE COMPANY ("Health Plan")

## APPROVAL TO COLLECT AND DISCLOSE HEALTH INFORMATION AND ENROLLMENT CERTIFICATIONS

(This form complies with the requirements of the Health Insurance Portability and Accountability Act of 1996.)

1. Collection of Health Information. I authorize any physician, hospital, or health care provider to furnish the Health Plan with health information, including medical records, claims, benefits and other administrative data that are personally identifiable, about myself and for any eligible dependents listed ("Health Information"), as may be requested by the Health Plan in order to process claims and provide health insurance coverage.

2. Disclosure of Health Information. I also authorize the Health Plan to disclose Health Information as necessary to conduct the Health Plan's business operations relating to the provision of health insurance coverage, including but not limited to developing disease management programs, quality measurements or clinical programs, payment of reinsurance claims, research for measurement purposes such as the development of reimbursements to providers or premium rates for employer groups and for all other purposes related to health care operations. This authorization shall remain in effect for the term of the insurance.

3. I hereby authorize my employer to make deductions required for my contribution for the monthly premium. I agree, for myself and for any eligible dependents listed, to abide by the rules and regulations of the Health Plan.

For purposes of this application for insurance, this authorization shall remain effective for a period of thirty months from the date of this authorization, or as otherwise required by law. For the purpose of collecting, disclosing and using information in connection with a claim for benefits, or any other activities of the Health Plan to provide health insurance coverage, this authorization shall remain in effect for the duration of the claim.

I represent that I have the authority to approve the collection and disclosure of Health Information on behalf of all persons enrolled in this health insurance coverage.

Please be advised that you, a person authorized to act on your behalf, or your authorized representative is entitled to receive a copy of this authorization.