MEDICAL COLLEGE OF GEORGIA
INSURANCE ENROLLMENT APPLICATION

SUBSCRIBER INFORMATION

Last Name **First Name** **MI** **Employee ID**

Mailing Address **City** **State** **Zip** **Telephone Number**

Birth Date **Sex** ☐ Male ☐ Female **Marital Status** ☐ Married ☐ Single ☐ Widowed

Status:

☐ Active ☐ Retired ☐ Divorced Date Divorce Final _____ ☐ Surviving Spouse Date of Spouse Death _____

Coverage Level Desired:

Medical:

Plan	Employee	EE+ Child	EE + Spouse	EE + Family
Indemnity	❑	❑	❑	❑
PPO	❑	❑	❑	❑
PPO Choice	❑	❑	❑	❑
HMO	❑	❑	❑	❑
HMO Choice	❑	❑	❑	❑

Dental:

Plan	Employee	EE + Child	EE + Spouse	EE + Family
USG	❑	❑	❑	❑
Delta	❑	❑	❑	❑

Are you eligible for Medicare? Yes No

You: ☐ Part A Effective Date: _____ Spouse: ☐ Part A Effective Date: _____
☐ Part B Effective Date: _____ ☐ Part B Effective Date: _____
☐ Part D Effective Date: ☐ Part D Effective Date:

Choose desired Effective date of coverage: **(If there is a transfer of coverage, give the name and SSN of previous subscriber)**

Medical ☐ Effective Date: _____ Dental ☐ Effective Date: _____

Name and SSN of Previous Subscriber: _____

Reason for Enrollment: _____

ELIGIBLE DEPENDENTS: If you checked Two-Person or Family, please list your dependents:

	Eligible Dependents**	Date of Birth	SEX M or F	Primary Care Physician #
Spouse				
Child				
Child				
Child				

Student Information: If any of your dependents are over the age of 19, they are not eligible for coverage unless they are full-time students. If any of your dependents are full-time students, the Benefits office must be provided with full-time student status. A full-time student will be covered to age 26, provided the Benefits office receives appropriate documents from school of attendance.

APPLICANT'S SIGNATURE: _____ DATE OF APPLICATION: _____