

SECTION A –GROUP DETAILS	
Company Name	Account #

SECTION B – GENERAL EMPLOYEE INFORMATION (Please print in blue or black ink)			
Employee's last name, first name, middle initial		Social Security Number	
Street number and street name			Apt. No.
City		State	Zip code
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (MM-DD-YYYY)	Spoken language
Area code/home phone number	Area code/work phone number	Area code/fax number	E-mail address
Date of employment (MM-DD-YYYY)	Job position	Office Location	Hours worked per week for this employer
Proportion of time spent on: Administration <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> % Supervisory <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> % Manual <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> % Travel <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> %			
If you are on COBRA or State Continuation, please indicate <input type="checkbox"/> COBRA <input type="checkbox"/> State Continuation		Effective date	Termination date

SECTION C - REFUSAL OF COVERAGE: Please complete only if refusing coverage.			
This is to certify that I have been given the opportunity to apply for group health coverage under the mentioned account number issued by Destiny Health. I understand the coverage available and I refuse coverage. All eligible Employees and their dependents must be listed as either enrolling or declining coverage when first eligible. If you or your eligible dependents do not enroll in Destiny Health when coverage is first made available and want to enroll in the future, coverage may be postponed and/or a preexisting condition exclusion may apply for up to 18 months. (Such exclusion would not apply to maternity benefits.) For more information, contact Destiny Health.			
I refuse coverage for: <input type="checkbox"/> myself <input type="checkbox"/> my spouse <input type="checkbox"/> my child(ren)			
Reasons for refusing coverage:	<input type="checkbox"/> individual coverage	<input type="checkbox"/> COBRA or state continuation	<input type="checkbox"/> retiring
	<input type="checkbox"/> covered under spouse	<input type="checkbox"/> government coverage	<input type="checkbox"/> other:
Employee's signature			Date
If you have refused coverage, you need not complete any further sections of this Enrollment Form.			

SECTION D - BENEFIT ELECTION		Effective Date
Coverage is for (check all that apply): <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) ____ (indicate number of child(ren) to be covered)		
Please indicate your benefit election below: (Note: Your election(s) are limited to the benefits your Employer has contracted with Destiny Health.)		
Dental/Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No	Coinsurance Level:	Personal Medical Fund™ (PMF) annual election (must be divisible by \$12.00)
Please select one of the following two ways that money can be withdrawn from your Personal Medical Fund™ (PMF) <input type="checkbox"/> An amount equal to expenses that accumulate to the PMF Safety Net (recommended) or , <input type="checkbox"/> All expenses eligible for reimbursement from the PMF, including those that do not accumulate to the PMF Safety Net. (This option may cause or accelerate reaching a Self Pay Gap.)		

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SECTION E – DEPENDENT INFORMATION: Please list your spouse and eligible child(ren) to be covered

Only list last names for dependents with a <i>different</i> last name than Employee.	Social Security Number	Date of birth (MM-DD-YYYY)	Sex (M/F)	Relationship to you *	
Spouse's last name, first name, middle initial					
Full name(s) of child(ren) Last name, first name, middle initial					* Use the following codes C=natural/adopted child F=foster child X=step child H=handicapped child S=legally married spouse
1.					
2.					
3.					
4.					
5.					

- Do you have legal custody of each child to be covered? Yes No If no, please comment in the space below
- Is each child to be covered *unmarried*? Yes No If no, please comment in the space below
- Does each child to be covered receive principal support from you? Yes No If no, please comment in the space below
- Does each child to be covered live with you? Yes No If no, please comment in the space below
- Is any child to be covered a Full-time Student age 19 or over? Yes No If yes, please complete Student Status section below

Use this space to comment or provide any other information you feel is pertinent.

Student Status: Complete for each Dependent child who is a Full-time Student over age 19.

Student name	Semester		Expected graduation year	School name	School City and State	School phone number
	Starts	Ends				

SECTION F – CHRONIC MEDICATION REGISTRATION

Do you or any member of your family have a chronic illness requiring the use of medication on a regular basis? Yes No
 In order for benefits to be considered for eligibility under this benefit, you will need to register with the Health Services Department at Destiny Health.

SECTION G – ELECTRONIC CLAIMS REIMBURSEMENT: This information is needed for the purpose of electronically transferring money to your account when you make claim reimbursement requests. We will NOT deduct money from your bank account.

Name of bank	Name of account holder	Account type: <input type="checkbox"/> Checking <input type="checkbox"/> Savings
Account number	Routing number	

Please attach a voided check or a deposit slip to ensure accuracy of your bank details

I agree to immediately advise Destiny Health in writing of any changes to any of the above information.

Signature of account holder	Date
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Page 2

SECTION H – PERSONAL MEDICAL FUND BENEFICIARY INFORMATION

Last name	First name	Middle initial	Relationship to you	%
1.				
2.				
3.				

* If no beneficiary is listed, the beneficiary will be your Estate.
If more than one beneficiary is named, they will share equally unless a percentage is indicated.

SECTION I – PROOF OF PRIOR COVERAGE

Did you or your dependent(s) have major medical coverage with any other carrier(s) within the past 12 months? Yes No

If yes, please complete the following for the most recent prior carrier. (To assure proper credit, please attach Certificates of Creditable Coverage from all insurance companies that you have had coverage with for the past 12 months.)

Employer name	Phone number		
Prior carrier name	Phone number		
Policy number	Effective date	Termination date	Check all who were covered: <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> child(ren)

SECTION J – COORDINATION OF BENEFITS

Will you or any of your dependents be covered under any health plan in addition to Destiny Health? Yes, please complete this section
 No, please skip to Section K

To coordinate claim payment with other health plans, we need information concerning employment and any other health coverage that may be available to your spouse or dependents. We require an update of this information yearly. Payment of your claims may be delayed without current information.

Policyholder's name	Policyholder's ID number	Plan number	Effective date	Please list who is covered:
	Insurance carrier's name	Address		Phone number
	Employer's name	Employer's address		Employer phone number
	Policyholder's ID number	Plan number	Effective date	Please list who is covered:
	Insurance carrier's name	Address		Phone number
	Employer's name	Employer's address		Employer phone number

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Page 3

SECTION K – ACKNOWLEDGEMENT, AUTHORIZATION, AND SIGNATURE

1. I certify that the information, statements, and answers on this form, and any attachments, are complete and true to the best of my knowledge. They are a part of this request for coverage under the Group Policy.
2. I apply for myself and any dependents detailed above to join the Destiny Health Plan and agree to adhere to and familiarize myself with the terms of coverage set forth in the Certificate and any amendments, riders, or other materials.
3. I have read, or had read to me, and understand the questions and responses and realize any false statements; omissions and/or material misrepresentation could cause coverage, if issued, to be cancelled as never effective. Any person, who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.
4. I authorize Group to make deductions from my earnings for my share of the cost, if any, for the benefits to which I may become entitled.
5. I authorize Destiny Health to administer my Personal Medical Fund in accordance with the PMF administration materials.
6. Upon termination of my membership from Destiny Health, I shall repay any amount by which claims were paid by the Personal Medical Fund that exceed cumulative contributions.
7. I authorize Destiny Health to use my social security number when required in connection with treatment, payment, and healthcare operations.
8. I wish to receive my Destiny Health Member Certificate by E-mail Accessing Destiny Health Website U.S. Mail
9. **Authorization to Release Medical Information.** I authorize any Medical Professional, hospital, clinic, laboratory, other medical or medically related facility, governmental agency, or other person or firm to provide the Destiny Health Insurance Company (“Company”) or their authorized representatives information, including copies of records, and medical, radiological and laboratory testing results, concerning advice, care or treatment provided to me and/or my dependent(s), including without limitation, information relating to mental illness or use of drugs or alcohol.
10. I understand that such information will be used by the Company for the purpose of evaluating my application for health insurance, or by Company representatives involved in evaluating, determining, or administering claims for insurance benefits of me or my dependent(s). I understand that I or any authorized representative will receive a copy of this authorization upon request. This authorization is valid from the date signed through the terms of coverage. A photocopy of this authorization shall be considered as effective and valid as the original.

Employee’s signature

Date

Spouse’s signature (if to be covered under this policy)

Date

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