PHP TPA Services
PO Box 9648, Fort Wayne, IN 46899
PH: 800-551-7334 | FAX: 260-436-7235
Phptpa.com

Ancon Construction, Group #8080

Employee Information - ***(As it appears on your Social Security Card.)***

Last Name	First	MI

Street Address	City	State	Zip

Social Security Number	Date of Birth	Sex at Birth	Marital Status

Telephone Number	E-Mail Address	Hire Date

Medical Plan Selection- *Check (√) only one*

- □ **PHP Freedom (IN)**
- □ **Cofinity (MI)**

Benefit Elections- *Check (√) only one.*

- □ **Employee**
- □ **Employee & Spouse**
- □ **Employee & Child(ren)**
- □ **Family**

□ **Waive Coverage**

Reason for Submission

□ **Application for membership**
- □ New Hire □ Re-Hire □ Open Enrollment
- □ Loss of other Coverage □ COBRA

Effective Date of Coverage: _____

□ **Status Change** Date of Change: _____
- □ Change to Part Time
- □ Change to Full Time

□ **Change** Date of Change: _____
- □ Add Dependent(s) listed below
- □ Delete Dependent(s) listed below

Reason for Change
- □ Divorce □ Marriage
- □ Birth □ Adoption
- □ Death
- □ Name Change
  Former Name: _____
- □ Other: _____

□ **Termination**
- □ Last Day Worked: _____
- □ Changing to Other Insurance: _____
- □ Retirement:_____

Dependents To Be Covered (List spouse and/or eligible dependents to be covered or terminated.)

Name (First, MI, Last)	Social Security #	Date of Birth (MM/DD/YY)	Sex	Other Coverage
Spouse			□ M □ F	□ Yes □ No
Dependent			□ M □ F	□ Yes □ No
Dependent			□ M □ F	□ Yes □ No
Dependent			□ M □ F	□ Yes □ No
Dependent			□ M □ F	□ Yes □ No
Dependent			□ M □ F	□ Yes □ No

If you, your spouse, or a financially dependent child is disabled, please fill in the information below. Proof from physician is required for dependent children over age 26. Please attach documentation.

Name: _____ □ EE □ SP □ CH

Name: _____ □ EE □ SP □ CH

Coordination of Benefits / Proof of Other Coverage – If not applicable, please put N/A in the field.

If you or any of your dependents covered under this plan are enrolled in another medical insurance plan, please complete the following.

Name of Person with other Insurance: _____ Relationship: _____

Insurance Company Name(s): _____ Policy Number: _____

The information I have supplied above is correct to the best of my knowledge. By accepting coverage in the group benefit plan, I hereby authorize all physicians or providers of service to furnish PHP TPA Services upon request, any and all reports and records or copies thereof concerning any illness, injury, or condition for which service was provided to me or my dependents after this date as well as before this date. If contributions are required under the plan, I authorize my employer to deduct from my earnings until further notice, my contributions for the group benefit plan.

Employee Signature		**Date**

This waiver will acknowledge that I have been informed of the terms of the above referenced Plan. Even though I am eligible to participate in such Plan, I hereby elect not to participate. I understand this waiver will remain in effect unless I have a Qualifying Special Enrollment Period as defined in the plan or if my employer allows an open enrollment period.

Waiver Signature		**Date**

Employer Verification		**Date**