__ C3 __ NON

Access Health Inc. ENROLLMENT, DENIAL, TERMINATION & CHANGE FORM

☐ Employee Enrollment C3 ☐ Termination of Coverage* ☐ Addition of Dependents ☐ Physician Change

☐ Employee Enrollment STD ☐ Address Change ☐ Card Replacement ☐ Decline coverage*

A. Complete & Return form by the 5th: 1200 Ransom, Suite 102, Muskegon, MI 49442 or fax (231) 728-5160

Name of Employer	Employer Address (Street, City, State, Zip Code)
Employee's Occupation/location: Date of Permanent Hire:	☐ Married ☐ Divorced ☐ Single ☐ Widowed
Employee Last Name First Legal Name Initial	Home Address (Street, City, State, **Zip Code**)

Phone: Home	Phone: Work	Email:

Complete for **all family members** First Name Initial Last Name	Social Security Number(record only)	Date of Birth	Sex	MI * Child	All children must have a Medicaid denial or certificate of credible coverage
Employee					☐ I currently do not have ANY health Coverage.
Spouse					☐ I currently do not have ANY health Coverage.
Dependents					☐ I currently do not have ANY health Coverage.
					☐ I currently do not have ANY health Coverage.
					☐ I currently do not have ANY health Coverage.

* Designate if child is on MI Child/Healthy Kids programs. Attach Medicaid Denial or Certificate of Credible Coverage.

PRIMARY CARE PHYSICIAN-VERIFY W/ THEIR OFC IF YOU HAVE CHOSEN A NEW PCP	Effective Date if new
Employee's Physician Name:	
Spouse's Physician Name:	
Dependent's Physician Name:	
Dependent's Physician Name:	

(Required) List the most recent or current health coverage: (INCLUDES MEDICAID, MUSKEGON CARE OR OTHER HEALTH COVERAGE)

Name: (s) ____________________ **Previous or Current Coverage** ____________________ **End Date** ____________________ **Comments:** ____________________

I hereby represent and agree that all statements in this request are full, complete and true, to the best of my knowledge and understand that the said statements form the basis upon which coverage will be made effective. I understand that omissions, misrepresentations or misstatements could result in the denial of an otherwise valid claim rescission, voiding, reformation or termination of coverage subject to the time limit on certain defense provisions set forth in the Policy. I understand explanation of the coverage as stated in the Handbook. I agree that my AH membership may be cancelled if I do not comply with my obligations as stated in the Handbook. My signature on this form authorizes all medical records, to be released to Access Health, Inc. for the period of eligibility for the enrolled members. I have received and read the Access Health Benefit Handbook.

______________________________ ______________________________

(EMPLOYEE SIGNATURE FOR ENROLLMENT or DENIAL) **(DATE)**

______________________________ ______________________________

(EMPLOYER SIGNATURE FOR ENROLLMENT) **(DATE)**

B.Termination/Denial- employer signature is required

☐ Other healthcare coverage ☐ Resigning Employment ☐ Declining Coverage ☐ AH Initiated

☐ Terminated by Employer ☐ Promotion ☐ Other Reason/List ______________________________

Employee: I am terminating my coverage: ______________________________. ______________

EMPLOYEE SIGNATURE **DATE**

Employer: I am terminating above employee's coverage for above listed reason:

______________________________ ______________

EMPLOYER SIGNATURE **DATE**

AH Office Use: Received: ______________ Effective Date: ______________ **** Due by the 5th of the previous month****

****THE ENROLLMENT OR TERMINATION DATE IS DETERMINED BY THE DATE THE FORM IS REVIEVED BY ACCESS HEALTH****