WESTERN MICHIGAN HEALTH INSURANCE POOL (WMHIP)

Name of Employer/Plan Sponsor: **WMHIP – Jenison Public Schools**	**Group #** 71565	**Plan Choice:** _____$1,500/$3,000 100% HSA **PAK A** $40 DRUG CARD _____$1,500/$3,000 100% HSA , **PAK C** $80 DRUG CARD

Check One: □ **Initial** □ **Change** □ **Termination** □ **Reinstatement**

Reason for Change (check all that apply): _____ Initial Eligibility Following Hire _____ Open Enrollment _____ Status Change: _____ _____ Other: _____	**Occupation:**	**Date of Hire:** **Hours Worked Weekly:**	**Effective Date of Coverage or Change:**

Employee Information

Employee Name (last, first, middle initial):		□ Female □ Male	Date of Birth:	Social Security Number:	
Street Address:			Telephone (including area code): Work: _____ Home: _____		
City:		State:		ZIP Code:	
Do you have other insurance through your spouse? □ Yes □ No	If Yes, Spouse's Employer:	Name of Insurance Carrier: □ Medical □ Dental □ Vision	Plan Number:	Type of Coverage: □ Single □ Family	
Does any proposed insured have other medical coverage? □ Yes □ No		Name of Insurance Carrier:	Plan Number:	Effective Date: _____ End Date: _____	
Are you or any of your dependents eligible for Medicare benefits? □ Yes Name: _____ □ No		Is any proposed insured currently covered under COBRA? □ Yes Effective Date: _____ □ No			

If coverage for a child or children is mandated by divorce decree or paternity order, please submit a copy of the decree or order with this form.
Who is responsible for coverage of child(ren) listed? □ Mother □ Father □ Both □ Other
Who has physical custody? □ Mother □ Father □ Other

Dependent's Name	Relationship to Child	Birth Date	Social Security Number	Sex	Termination Date
Spouse:				□ Female □ Male	
Child:	□ Natural □ Step			□ Female □ Male	
Child:	□ Natural □ Step			□ Female □ Male	
Child:	□ Natural □ Step			□ Female □ Male	
Child:	□ Natural □ Step			□ Female □ Male	

EMPLOYEE CERTIFICATION AND SIGNATURE

- To the best of my knowledge and belief, the information I have provided on this form is correct. I hereby certify that the dependents listed above are my dependents within the definition contained in the group Plan of my employer. I agree to notify the Plan Administrator if and when there is a change in any dependent's status.
- The current benefits have been explained to me thoroughly. I hereby request coverage as outlined above under the Plan offered by my employer for which I am or may become eligible, and I authorize my employer to deduct any required contribution from my earnings. I reserve the right to revoke this authorization at any time upon written notice.
- **I understand that any person who knowingly and with intent to defraud submits an application or files a claim containing any materially false or misleading information commits a fraudulent act, which is a crime.**
- I understand that in the event of any discrepancy between this enrollment form and any policy in which I am enrolling, the terms of the policy shall apply.
- I understand my coverage begins on the effective date assigned by the Administrator, provided I have met all eligibility requirements.

EMPLOYEE SIGNATURE: _____ DATE: _____