



Group number: _____

Medical Application Form

Instructions: Please complete boxes outlined in **RED**

A: Personal Information

Last Name: _____ Middle Initial: _____ First Name: _____
Date of Birth: ____/____/____ Social Security Number: _____
Street Address: _____ Apt #: _____
City: _____ State: _____ Zip Code: _____
Home Phone Number: _____ E-mail Address: _____
Marital Status: Single Married Divorced Widowed
Gender: Male Female Tobacco Usage: Yes No
Occupation: _____ Date of Hire: ____/____/____
Hours: _____ Salary: _____

B: Dependents to be Insured (Leave BLANK if coverage is NOT elected)

Dependent 1

Last Name: _____ Middle Initial: _____ First Name: _____
Date of Birth: ____/____/____ Social Security Number: _____
Gender: Male Female

Dependent 2

Last Name: _____ Middle Initial: _____ First Name: _____
Date of Birth: ____/____/____ Social Security Number: _____
Gender: Male Female

Dependent 3

Last Name: _____ Middle Initial: _____ First Name: _____
Date of Birth: ____/____/____ Social Security Number: _____
Gender: Male Female

Dependent 4

Last Name: _____ Middle Initial: _____ First Name: _____
Date of Birth: ____/____/____ Social Security Number: _____
Gender: Male Female

C: Prior Coverage

Did you have prior medical coverage?

Yes

No

If yes, please fill out the fields below:

Name of Previous Carrier:

Date of Termination: ____/____/____

Reason of Termination: _____

Covered Individuals:

Last Name:

Middle Initial:

First Name:

Last Name:

Middle Initial:

First Name:

Last Name:

Middle Initial:

First Name:

Last Name:

Middle Initial:

First Name:

D: Acknowledgement of Coverage and Signature

Name Printed:

Signature:

Signature Date: ____/____/____