Johns Hopkins Health System Corporation/Johns Hopkins Hospital
Enrollment Application

(PLEASE PRINT – PRESS FIRMLY USING BALL POINT PEN)

Send application directly to Intrastaff - JHMMC

10751 Falls Road, Falls Concourse suite #275, Lutherville, MD 21093

P: (410) 583-2950 • F: (410) 847-3659

NEW ENROLLMENT/CHANGES IN ENROLLMENT

1. TYPE OF REQUEST (CHECK BOXES, AS APPROPRIATE) ☐ NEW APPLICANT ☐ ADD SPOUSE/DEPENDENT ☐ DELETE SPOUSE/DEPENDENT ☐ CHANGE NAME/ADDRESS

MEDICAL		DENTAL		VISION	For DPC Plan selection: Please indicate all members selecting DIRECT PRIMARY CARE (DPC) as primary care provider
☐ PPO Plan ☐ EPO Plan ☐ DPC Plan	☐ EMPLOYEE ☐ EMPLOYEE & SPOUSE ☐ EMPLOYEE & CHILD(REN) ☐ EMPLOYEE & FAMILY ☐ OPT OUT OF MEDICAL	☐ HIGH OPTION ☐ COMPREHENSIVE	☐ EMPLOYEE ☐ EMPLOYEE & SPOUSE ☐ EMPLOYEE & CHILD(REN) ☐ EMPLOYEE & FAMILY ☐ OPT OUT OF DENTAL	☐ EMPLOYEE ☐ EMPLOYEE & SPOUSE ☐ EMPLOYEE & CHILD(REN) ☐ EMPLOYEE & FAMILY ☐ OPT OUT OF VISION	☐ Employee ☐ Spouse ☐ Dependent 1 ☐ Dependent 2 ☐ Dependent 3 Must be 18 years or older *Complete section 16 below with PCP provider selection*

APPLICANT INFORMATION

2. NAME – LAST	FIRST	INITIAL	3. SOCIAL SECURITY NO	4. DATE OF EMPLOYMENT	
5. MAILING ADDRESS		CITY	STATE	ZIP CODE	COUNTY
6. HOME PHONE NO.	WORK PHONE NO.	7. MARITAL STATUS ☐ SINGLE ☐ MARRIED	8. EMPLOYER		

9. ARE YOU RETIRED? ☐ YES ☐ NO

10 ARE YOU CURRENTLY ACTIVELY AT WORK? ☐ YES ☐ NO IF NO, GIVE REASON:

SPOUSE/DEPENDENT INFORMATION (COMPLETE THIS SECTION FOR YOURSELF AND COVERED DEPENDENTS)

	11. NAME (LAST, FIRST, MIDDLE INITIAL)	12. SEX (M/F)	13. BIRTHDATE MO	DAY	YR	14. RELATIONSHIP	15. DISABLED (Y/N)	16. LIST NAME & ID NUMBER OF THE PRIMARY CARE PHYSICIAN FROM THE DIRECTORY FOR EACH MEMBER	PCP I.D. NO.	CURRENT PATIENT Y/N
SELF	SOC. SEC. NO.							PCP ☐ Direct Primary Care		
SPOUSE	SOC. SEC. NO.							PCP ☐ Direct Primary Care		
DEP 1	SOC. SEC. NO.					☐ CHILD ☐ STEPCHILD ☐ OTHER (SPECIFY)		PCP ☐ Direct Primary Care		
DEP 2	SOC. SEC. NO.					☐ CHILD ☐ STEPCHILD ☐ OTHER (SPECIFY)		PCP ☐ Direct Primary Care		
DEP 3	SOC. SEC. NO.					☐ CHILD ☐ STEPCHILD ☐ OTHER (SPECIFY)		PCP ☐ Direct Primary Care		

17. IS YOUR SPOUSE/DEPENDENT EMPLOYED? ☐ YES ☐ NO IF YES, NAME OF EMPLOYER ____

18. DO YOU OR ANY OF YOUR DEPENDENTS HAVE OTHER:
A. GROUP HEALTH COVERAGE? ☐ YES ☐ NO IF YES, IS COVERAGE ☐ SINGLE OR ☐ FAMILY
B. GROUP DENTAL COVERAGE? ☐ YES ☐ NO IF YES, IS COVERAGE ☐ SINGLE OR ☐ FAMILY

IF YES,
NAME OF HEALTH INSURANCE CARRIER: ____ POLICY NUMBER: ____
NAME OF DENTAL INSURANCE CARRIER: ____ POLICY NUMBER: ____
NAME OF INSURED: ____ DATE OF BIRTH: ____ EFFECTIVE DATE OF COVERAGE: ____ TERMINATION DATE OF COVERAGE: ____
FAMILY MEMBER COVERED AND RELATIONSHIP: ____

19. IF YOU OR ANY DEPENDENT LISTED ABOVE WILL BE COVERED BY MEDICARE WHILE ENROLLED IN THIS HEALTH PLAN, PLEASE COMPLETE THE FOLLOWING:
ENROLLEE NAME: ____ MEDICARE ____ PART A EFFECTIVE DATE ____ PART B EFFECTIVE DATE ____
ENROLLEE NAME: ____ MEDICARE NO. ____ PART A EFFECTIVE DATE ____ PART B EFFECTIVE DATE ____

20. I apply for EHP enrollment for the persons listed, and agree that I and my family members shall be covered according to the terms of the Plan. I hereby authorize deductions from my earnings of any required contribution as applicable. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medical-related facility, insurance company, the Medical Information Bureau, or other organization, institution, or person that has any records or knowledge of me or my family's health to give EHP such information. A photographic copy of this authorization shall be as valid as the original.
To the best of my knowledge and belief, all statements to the questions in the application are complete and true, and I agree that they will be the basis of the issuance of any coverage. I will notify EHP promptly in writing concerning any changes in the above information.
Any material misrepresentation, whether intentional or not, may result in denial of a claim or retroactive cancellation of coverage.

APPLICANT SIGNATURE: ____ DATE: ____

FOR EMPLOYER/GROUP USE ONLY

REASON FOR SUBMITTING APPLCIATION	EFFECTIVE DATE: ____	Salary Tier	GROUP NO: ____
☐ NEW HIRE ☐ LATE ENROLLEE ☐ OPEN ENROLLMENT/ELECTION PERIOD ☐ EMPLOYMENT STATUS CHANGE ☐ FAMILY STATUS CHANGE	☐ MEDICAL ☐ OTHER	☐ Under $50K ☐ $50K to $120K ☐ $120 K and over	SUBGROUP: ____ WORK LOCATION (IF APPLICABLE ____

EHP USE ONLY

INITIAL
DATE