

GVHP MEMBERSHIP APPLICATION & CHANGE FORM

HMO Choice Plus Other _____

Group ID: _____

REASON FOR APPLICATION (Please check one):

Site ID: _____

Contract Addition Date: _____

Contract Termination Date: _____

Address Change

- OPEN ENROLLMENT
- REINSTATE COVERAGE
- LOST OTHER COVERAGE
- OTHER _____

- NEW HIRE
- PT TO FT

- TERMINATION OF EMPLOYMENT
- CHANGE OF INSURANCE
- VOLUNTARY DISENROLLMENT
- OTHER _____
- DEATH
- RETIREMENT
- LAYOFF

PREVIOUS ADDRESS _____

Name Change (Previous Name): _____

Dependent Addition Date: _____

Dependent Termination Date: _____

Site Transfer Date: _____

- BIRTH
- LOST OTHER COVERAGE
- OTHER _____

- MARRIAGE
- ADOPTION

- INELIGIBLE DUE TO AGE
- NO LONGER FULL TIME STUDENT
- OTHER _____
- DIVORCE
- DEATH

ADD TO COBRA RETIREMENT

OTHER _____

Other (Please Specify): _____

(PLEASE PRINT OR TYPE POLICY HOLDER INFORMATION)

Employee Last Name:		First Name:		Middle Initial:	Ethnicity (Optional): <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> African American/Black <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Other		
Birth Date:	Social Security Number:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female				
Home Address:			City:	State:	Zip Code:	Marital Status:	
Home Telephone: () ()	Work Telephone: () ()	Employer Name:		E-mail:		Date of Hire:	

Please list any dependents you wish to ADD to or REMOVE from your contract in the space provided below:

Last Name	First Name	Middle Initial	Social Security Number	Relationship to subscriber	Sex M/F	Birth Date	Add Or Remove?	Full Time Student?
			- -			- -		
			- -			- -		
			- -			- -		
			- -			- -		
			- -			- -		
			- -			- -		
			- -			- -		

IMPORTANT: You must select a Grand Valley Family Health Center for you and your family members. Please check one box.

- Beckwith (*NE Grand Rapids*)
 Jenison
 Rockford
 Walker
 Wyoming
 224-1515
 457-3830
 866-9568
 784-4717
 532-1100

If any family members live at a different address and/or need to select a Family Health Center different than yours, please list:

Name:	Address:	Family Health Center:

PLEASE ANSWER QUESTIONS BELOW (Coordination of Benefits)

If you, your spouse, or any dependents are covered by Medicare or any other insurance policy providing medical benefits along with Grand Valley Health Plan, please complete this section.

Where are your claims sent?	Company Name / Address		Policy Number	
Policyholder information	Name of policyholder		Birth Date / /	Employer
	Family Member(s) covered (1)		2)	3)
Reason for Medicare: <input type="checkbox"/> End stage renal disease <input type="checkbox"/> Disabled <input type="checkbox"/> Over age 65 <input type="checkbox"/> Over age 65 and Working		Medicare Effective Date		

PLEASE SIGN THIS APPLICATION AND RETURN TO YOUR PERSONNEL OFFICE

In making this Application for, or change in, membership, I agree to the following for myself and my dependents:

1. That this Application and the acceptance thereof constitutes an agreement to the terms and conditions contained in the GVHP Subscriber Certificate of Coverage and summarized in the GVHP enrollment materials.
2. That I authorize my employer/group to deduct from my earned or accrued wages and remit the prevailing fee, if any, that may be required for the cost of this coverage.
3. That I acknowledge GVHP's right to conduct a utilization review program of health services, and to coordinate benefits and/or reimbursements with other insurance programs.
4. That all information furnished by me is true and complete to the best of my knowledge.
5. That I understand I am no longer eligible for this plan if I am out-of-area greater than 90 consecutive days.
6. That I understand that GVHP does not offer a Medicare-gap policy.

SUBSCRIBER SIGNATURE _____ DATE: _____

EMPLOYER SIGNATURE _____ TITLE: _____ DATE: _____

White - GVHP

Yellow - EMPLOYER

Pink - SUBSCRIBER