

# Preferred Plus of Kansas, Inc. ("PPK")

High Option

Low Option

## Enrollment Form

PLEASE TYPE OR PRINT

DO NOT WRITE IN SHADED AREA

SSN	Employee's Legal Last Name	Legal First Name	MI
Street Address		City	State
Home Phone	Work Phone	Birth Date	Zip Code
Primary Care Physician (If a PCP is not listed we will select one for you.)		Male Female	Your Employer/Company Name
		PCP ID #	Single Married Common Law Married
			Group Number

**PLEASE LIST SPOUSE YOU WISH TO ENROLL IN MEDICAL COVERAGE (if common law married attach affidavit)**

Last Name	First Name	MI	Birth Date	Sex	SSN	Primary Care Physician	PCP ID #
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**PLEASE LIST CHILDREN AND OTHER ELIGIBLE DEPENDENTS YOU WISH TO ENROLL IN MEDICAL COVERAGE**

Last Name	First Name	MI (List address if different)	Birth Date	Sex	SSN	Relationship	Full Time College Student (Please attach schedule) Yes No	Primary Care Physician	PCP ID #

Are you or any person listed above totally disabled? Yes No If so, who is disabled? \_\_\_\_\_

After you are enrolled in PPK, will you or any person above be covered by other health insurance? Yes No If yes, what insurance \_\_\_\_\_

Insurance Company phone number \_\_\_\_\_ Policyholder's Name \_\_\_\_\_ Policyholder's Date of Birth \_\_\_\_\_ Policyholder's I.D.# \_\_\_\_\_

Names of those covered \_\_\_\_\_

I hereby apply for enrollment for the individual(s) listed above. I understand and accept that covered services will only be provided by the specific health care providers and institutions authorized by Preferred Plus of Kansas, Inc. subject to the terms of the employer group agreement contract. I authorize my employer to deduct from my earnings my contribution to the premium. I hereby consent to the release of information or medical records concerning services or supplies provided to me or my covered dependents by any health care provider, allied health professional, hospital or medical care institution to PPK, or its designee for the purpose of quality or utilization review or payment of a claim. A copy of this consent is available upon request. The consent is valid for the duration of the coverage. I represent that the information I have provided on this form is correct and that I do hereby agree to the terms and conditions set out in the plan.

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

**MUST BE COMPLETED BY EMPLOYER**

Date of Employment: \_\_\_\_\_ Please check one of the following: New Hire \_\_\_\_\_ Open Enrollment \_\_\_\_\_ Loss of other group coverage: \_\_\_\_\_ Date of loss: \_\_\_\_\_

Other reason (Please list reason such as: Change in family status, PT to FT, Loss of other coverage): \_\_\_\_\_ Date of Qualifying Event: \_\_\_\_\_

Effective Date of Coverage: \_\_\_\_\_ Employer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

an affiliated company of

