Physicians Health™
BENEFIT TRUST

Submit to:
Physicians Health c/o MMI, Inc.
441 West Plumb Lane
Reno, NV 89509

e: benefits@physicianshealth.org
t: (866) 337.8088
f: (775) 337.8099

Legal Name: PHA Group Benefit Trust
Version: PHBT / E&W / 0808

Enrollment Representative: _____ **Representative Phone:** _____

ENROLLMENT / WAIVER FORM

Please complete this form in "**BLACK**" ink only and print legibly

☐ **New Enrollee Information (Complete sections I, II, III & IV and provide signature)**
☐ **Coverage Waiver (Complete sections I, II, & V ONLY and provide signature)**

SECTION I. EMPLOYER INFORMATION

Employer Name:_____ Location (if more than one):_____

SECTION II. EMPLOYEE INFORMATION

Last Name:	First Name:	MI:	
Date of Hire:	Hours Worked Per Week:	Occupation:	
Applicant Social Security Number: ___ - ___ - ____	Date of Birth: / /		
Address:	City:	State:	Zip:

SECTION III. COVERAGE SELECTION (Subject to the plan options selected by your employer)

☐ Employee Only (EE) ☐ EE + Spouse ☐ EE + Child(ren) ☐ EE + Family

SECTION V. FAMILY INFORMATION (please complete for all persons to be covered)

First Name & M.I. (last name if different)	Date of Birth	Social Security No.
Spouse:	/ /	
Child:	/ /	
Child:	/ /	
Child:	/ /	
Child:	/ /	

NOTE: Full time students ages 19 - 25 must carry 12 credits per semester. Student certification required from accredited college.

I understand that any information that has been obtained on the basis for the Plan to issue a proposal for medical benefits for my employer shall be the basis for the Plan to issue a Summary Plan Description. I understand and agree that the Plan Administrator is not bound by any statement made by or to any agent unless written herein. I agree that no coverage will be effective until the date specified by the Plan Administrator. I hereby apply for participation in the Plan for myself and my dependents listed above.

Applicant's Signature: _____ Date: _____

SECTION V. COVERAGE WAIVER (Complete this section ONLY if you are waiving coverage)

1. I waive coverage for: ☐ Self (including Spouse and Dependent(s)) ☐ Spouse ☐ Dependents
2. Reason for waiving coverage: ☐ Covered under spouse/parent's group plan ☐ Covered under other policy ☐ Not interested, have no other coverage

If I have waived coverage for myself and/or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself and/or my dependents in this plan, provided that I request enrollment within 31 days after my other coverage ends because of involuntary loss of coverage (divorce, death, legal separation, termination of employment, reduction in number of hours of employment). In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 31 days after the date of the event. I further understand that if this form is submitted after the enrollment period, and my employer has elected to cover late enrollees, a longer limitation may apply to pre-existing conditions disclosed herein, even though I may be accepted for coverage.

Applicant's Signature: _____ Date: _____