

VIRGINIA APPLICATION



P.O. Box 942, Frederick, MD 21705-0941

COBRA

First Date on COBRA _____

- New Enrollment
- Dependent Addition
- Re-enrollment
- Disenroll
- Address Change
- Conversion
- Name Change

A. OTHER INSURANCE INFORMATION

Do you or any MLH family member have other health insurance that will be in effect at the same time as your MLH policy? Yes No

Health Insurance Company _____

Phone Number _____

Policy Number _____

In the past seven years, have you or any family member been treated for injuries from an accident? Yes No

Are you or any MLH family member covered by Medicare? Yes No
If yes, Medicare number: _____

B. MEMBER INFORMATION

Group Policy Number

Effective Date

Member Number

Social Security Number

M56542

Name (Last) (First) (MI)

Street Address or P.O. Box Number

Birth Date Sex Previous Membership in MLH?
 Yes No

City State ZIP Code

Home Phone () E-Mail Address

Marital Status Single Married Divorced Separated
If adding a spouse, please give date of marriage:

Name of Employer

Date Employed

Business Phone ()

C. DEPENDENT INFORMATION

Note: All unmarried children ages 19-23 must be full-time students or permanently disabled to be eligible for coverage. (Attach additional sheets if needed.)

0 2 Spouse's Name (Last) (First) (MI) Date of Birth Social Security Number
Disabled? Yes No Sex Male Female

0 3 First Eligible Child's Name (Last) (First) (MI) Date of Birth Sex Male Female Social Security Number
Student Over 18? Yes No Disabled? Yes No

0 4 Second Eligible Child's Name (Last) (First) (MI) Date of Birth Sex Male Female Social Security Number
Student Over 18? Yes No Disabled? Yes No

0 5 Third Eligible Child's Name (Last) (First) (MI) Date of Birth Sex Male Female Social Security Number
Student Over 18? Yes No Disabled? Yes No

If enrolling a newborn: Date of discharge from Hospital: _____ Was this later than the mother's discharge date? Yes No

D. EMPLOYEE AND/OR DEPENDENT REMOVAL FROM HEALTH PLAN

Employee's Name (Last) (First) (MI)	Last Day of Coverage	01	Reason Code	Enter reason code(s) in box(es) at left: 1. Changed employment 2. Deceased 3. Dissatisfied 4. No longer eligible 5. Other insurance
Spouse's Name (Last) (First) (MI)	Last Day of Coverage	02	Reason Code	
Child's Name (Last) (First) (MI)	Last Day of Coverage	03	Reason Code	

E. CONDITIONS OF ENROLLMENT

If you have any questions concerning the benefits and services provided by or excluded under this agreement, please contact a Member Services Representative before signing this application.

I hereby apply for membership in the Health Plan for myself and any listed dependents. I have read this application in its entirety, including the Approval to Collect and Disclose Health Information and Enrollment Certifications statement on the other side of this application.

By my signature below, I represent that I understand and agree to all terms and conditions stated in this application, and that all information given by me is accurate, current and complete to the best of my knowledge and belief.

Signature of Member or Member's representative _____ Date _____

Printed name of Member or Member's representative: _____

Member representative's relationship to the Member and statement of the representative's capacity: _____

Group Authorization _____ Date _____

MAMSI Life and Health Insurance Company

Corporate Headquarters: 4 Taft Court, Rockville, MD 20850 • www.mamsi.com