



417 Walnut Street
Harrisburg, PA



ENROLLMENT FORM
Please Print or Type All Answers

Applicant's Full Name: Last		First	MI	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Legally Separated	<input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Applicant's Home Address		Street	City	County	State	Zip Code
Social Security No.		Date of Birth		Home Phone Number Area Code ()		
Employer's Name		Date of Hire: _____		Daytime Phone Number		
		Effective Date: _____		Area Code ()		
Address				Group Number		
City	County	State	Zip Code	Location of Employment		
Beneficiary			Relationship to you			

IF DEPENDENT COVERAGE IS REQUESTED, LIST ALL ELIGIBLE DEPENDENTS

Full name (first, last, middle initial)	Date of Birth (MM/DD/YY)	Age	Male Female	Social Security No.	If a dependent child is 19 but less than 25 years of age, is he or she a full-time college student or disabled?
Spouse (full name):			<input type="checkbox"/> Male <input type="checkbox"/> Female		
Child (full name)			<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Full-time Student <input type="checkbox"/> Disabled
Child (full name)			<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Full-time Student <input type="checkbox"/> Disabled
Child (full name)			<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Full-time Student <input type="checkbox"/> Disabled

MEDICAL PLAN <i>Select the plan in which you are enrolling</i>	<input type="checkbox"/> Gold	Monthly Rate _____
	<input type="checkbox"/> Silver	
<i>Note: Discount Vision is included with each medical plan.</i>		

The coverage for which you are applying includes a Pre-existing limitation which states: We will not pay for a condition for which you, your spouse or covered dependent has received medical treatment, care or advise within 6 months before being covered under this policy. This Pre-existing limitation does not apply if:

- a) you, your spouse or covered dependent has received no such treatment, care or advise for that condition for 6 straight months after being covered;
- b) coverage has been in effect for 12 months; or
- c) the condition is a pregnancy.

This Pre-existing limitation can be reduced by the period of time you, your spouse or dependents were previously insured under a prior plan , if coverage under this plan if effective within 63 days of termination of your prior plan.

I hereby apply for coverage indicated. I understand this application is subject to approval by American Sentinel Insurance Company and/or its reinsurers, and any coverage provided is also subject to the terms of agreement and/or contracts issued to me. Any persons or organizations, or any government agency having provided health care services to me, or any person named on this application or attachments to this application, either prior to or during the period of the contract, is authorized to furnish to American Sentinel Insurance Company, and/or its reinsurers any information or records related to any claims submitted. "Any person knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act, which is a crime and subject to criminal and civil penalties." I verify that statements made in this application are true and correct.

Signature _____

Date _____