



**MEDICAL ENROLLMENT APPLICATION**  
Please print – use ballpoint pen and press firmly

*If you are not electing medical coverage through Atlantic Concrete, please refer to highlighted section below.*

NAME (LAST, FIRST, MIDDLE INITIAL)		DATE OF BIRTH
ADDRESS	CITY	DATE OF HIRE
STATE	ZIP	COVERAGE EFF. DATE
CONTACT INFORMATION: HOME PHONE #		CELL PHONE #
SEX <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> LEGALLY SEPARATED <input type="checkbox"/> WIDOWED	SOCIAL SECURITY NO.

<b>GROUP NAME: ATLANTIC CONCRETE</b>	<b>GROUP #578</b>
<input type="checkbox"/> NEW ENROLLMENT <input type="checkbox"/> REHIRE <input type="checkbox"/> MARRIAGE <input type="checkbox"/> UNPAID LEAVE OF ABSENCE <input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> ADDRESS CHANGE <input type="checkbox"/> CHANGE NAME <input type="checkbox"/> DEPENDENT DEATH <input type="checkbox"/> ADD NEWBORN <input type="checkbox"/> ADD CHILD PER COURT ORDER <input type="checkbox"/> RETIREMENT <input type="checkbox"/> CHANGE IN EMPLOYMENT STATUS <input type="checkbox"/> OTHER _____	

LEVEL OF COVERAGE:	EMPLOYEE ONLY	EMPLOYEE/SPOUSE	EMPLOYEE/CHILD	FAMILY
MEDICAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PRIMARY CARE PHYSICIAN (PCP):				
PCP ADDRESS:				
PCP PHONE NUMBER:				

DEPENDENT'S NAME	SOCIAL SECURITY NO.	DATE OF BIRTH	SEX	RELATIONSHIP			
				SPOUSE	SON	DGTR	OTHER

**NOTE: IF THE LAST NAME OF ANY DEPENDENT IS DIFFERENT FROM YOURS, PLEASE EXPLAIN.**

I authorize my employer to deduct the appropriate contribution from my earnings, if applicable.     Yes     No

I do not desire employee coverage  dependent coverage  and understand that a qualified change in Family Status or Loss of Coverage (Special Enrollment) will be required to enroll at a later date.

I hereby authorize any provider of health care services, claim administrators, insurers, reinsurers, and others who have a legitimate need for such information for the purpose of review, investigation, or evaluation of a claim to supply each other with information about my health status and health care services provided to me. I agree that a photographic copy of this authorization is as valid as the original.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_