



Johns Hopkins Health System Corporation/Johns Hopkins Hospital Enrollment Application

(PLEASE PRINT – PRESS FIRMLY USING BALL POINT PEN)
Send application directly to Intrastaff - JHMMC
10751 Falls Road, Falls Concourse suite #275, Lutherville, MD 21093
P: (410) 583-2950 • F: (410) 847-3659

NEW ENROLLMENT/CHANGES IN ENROLLMENT											
1. TYPE OF REQUEST (CHECK BOXES, AS APPROPRIATE) ☐ NEW APPLICANT ☐ ADD SPOUSE/DEPENDENT ☐ DELETE SPOUSE/DEPENDENT ☐ CHANGE NAME/ADDRESS											
MEDICAL ☐ PPO Plan ☐ EMPLOYEE ☐ EPO Plan ☐ EMPLOYEE & SPOUSE ☐ DPC Plan ☐ EMPLOYEE & CHILD(REN) ☐ EMPLOYEE & FAMILY ☐ OPT OUT OF MEDICAL		DENTAL ☐ HIGH OPTION ☐ EMPLOYEE ☐ COMPREHENSIVE ☐ EMPLOYEE & SPOUSE ☐ EMPLOYEE & CHILD(REN) ☐ EMPLOYEE & FAMILY ☐ OPT OUT OF DENTAL		VISION ☐ EMPLOYEE ☐ EMPLOYEE & SPOUSE ☐ EMPLOYEE & CHILD(REN) ☐ EMPLOYEE & FAMILY ☐ OPT OUT OF VISION		For DPC Plan selection: Please indicate all members selecting DIRECT PRIMARY CARE (DPC) as primary care provider ☐ Employee ☐ Dependent 1 ☐ Spouse ☐ Dependent 2 ☐ Dependent 3 Must be 18 years or older Complete section 16 below with PCP provider selection					
APPLICANT INFORMATION											
2. NAME – LAST FIRST INITIAL			3. SOCIAL SECURITY NO		4. DATE OF EMPLOYMENT						
5. MAILING ADDRESS				CITY		STATE		ZIP CODE	COUNTY		
6. HOME PHONE NO.			WORK PHONE NO.		7. MARITAL STATUS ☐ SINGLE ☐ MARRIED		8. EMPLOYER				
9. ARE YOU RETIRED? ☐ YES ☐ NO		10 ARE YOU CURRENTLY ACTIVELY AT WORK? ☐ YES ☐ NO IF NO, GIVE REASON:									
SPOUSE/DEPENDENT INFORMATION (COMPLETE THIS SECTION FOR YOURSELF AND COVERED DEPENDENTS)											
11. NAME (LAST, FIRST, MIDDLE INITIAL)		12. SEX (M/F)	13. BIRTHDATE MO DAY YR			14. RELATIONSHIP	15. DISABLED (Y/N)	16. LIST NAME & ID NUMBER OF THE PRIMARY CARE PHYSICIAN FROM THE DIRECTORY FOR EACH MEMBER		PCP I.D. NO.	CURRENT PATIENT Y/N
SELF								PCP ☐ Direct Primary Care			
	SOC. SEC. NO.										
SPOUSE								PCP ☐ Direct Primary Care			
	SOC. SEC. NO.										
DEP 1						☐ CHILD ☐ STEPCHILD ☐ OTHER (SPECIFY)		PCP ☐ Direct Primary Care			
	SOC. SEC. NO.										
DEP 2						☐ CHILD ☐ STEPCHILD ☐ OTHER (SPECIFY)		PCP ☐ Direct Primary Care			
	SOC. SEC. NO.										
DEP 3						☐ CHILD ☐ STEPCHILD ☐ OTHER (SPECIFY)		PCP ☐ Direct Primary Care			
	SOC. SEC. NO.										
17. IS YOUR SPOUSE/DEPENDENT EMPLOYED? ☐ YES ☐ NO IF YES, NAME OF EMPLOYER _____											
18. DO YOU OR ANY OF YOUR DEPENDENTS HAVE OTHER: A. GROUP HEALTH COVERAGE? ☐ YES ☐ NO IF YES, IS COVERAGE ☐ SINGLE OR ☐ FAMILY B. GROUP DENTAL COVERAGE? ☐ YES ☐ NO IF YES, IS COVERAGE ☐ SINGLE OR ☐ FAMILY IF YES, NAME OF HEALTH INSURANCE CARRIER: _____ POLICY NUMBER: _____ NAME OF DENTAL INSURANCE CARRIER: _____ POLICY NUMBER: _____ NAME OF INSURED: _____ DATE OF BIRTH: _____ EFFECTIVE DATE OF COVERAGE: _____ TERMINATION DATE OF COVERAGE: _____ FAMILY MEMBER COVERED AND RELATIONSHIP: _____											
19. IF YOU OR ANY DEPENDENT LISTED ABOVE WILL BE COVERED BY MEDICARE WHILE ENROLLED IN THIS HEALTH PLAN, PLEASE COMPLETE THE FOLLOWING: ENROLLEE NAME: _____ MEDICARE PART A EFFECTIVE DATE _____ PART B EFFECTIVE DATE _____ ENROLLEE NAME: _____ MEDICARE NO. _____ PART A EFFECTIVE DATE _____ PART B EFFECTIVE DATE _____											
20. I apply for EHP enrollment for the persons listed, and agree that I and my family members shall be covered according to the terms of the Plan. I hereby authorize deductions from my earnings of any required contribution as applicable. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medical-related facility, insurance company, the Medical Information Bureau, or other organization, institution, or person that has any records or knowledge of me or my family's health to give EHP such information. A photographic copy of this authorization shall be as valid as the original. To the best of my knowledge and belief, all statements to the questions in the application are complete and true, and I agree that they will be the basis of the issuance of any coverage. I will notify EHP promptly in writing concerning any changes in the above information. Any material misrepresentation, whether intentional or not, may result in denial of a claim or retroactive cancellation of coverage.											
APPLICANT SIGNATURE: _____ DATE: _____											

FOR EMPLOYER/GROUP USE ONLY				EHP USE ONLY	
REASON FOR SUBMITTING APPLICATION ☐ NEW HIRE ☐ LATE ENROLLEE ☐ OPEN ENROLLMENT/ELECTION PERIOD ☐ EMPLOYMENT STATUS CHANGE ☐ FAMILY STATUS CHANGE		EFFECTIVE DATE: _____ ☐ MEDICAL ☐ OTHER	Salary Tier ☐ Under \$50K ☐ \$50K to \$120K ☐ \$120 K and over	GROUP NO: _____ SUBGROUP: _____ WORK LOCATION (IF APPLICABLE) _____	INITIAL DATE