Preferred Health Systems **Enrollment Form** *Please type or print. Do not write in shaded areas.* Group # _____

Plan Selection: ☐ Option 1 ☐ Option 2 ☐ Option 3 ☐ _____	Your Employer / Company Name:		
SSN:	Employee's Legal Last Name:	Legal First Name:	MI:
Street Address:	City, State and Zip:		
Home Phone:	Work Phone:	Birth Date:	Sex: ☐ Single ☐ Married ☐ Common Law Married **(attach affidavit)**
Primary Care Physician (PCP): *If not listed, we will select one for you.*	PCP ID #:	EPO ☐	

Please list spouse you wish to enroll in medical coverage.

Legal Last Name	Legal First Name	MI	Birth Date	Sex	SSN	Primary Care Physician	PCP ID #

Please list children and other eligible dependents you wish to enroll in medical coverage (list address if different).

Legal Last Name	Legal First Name	MI	Birth Date	Sex	SSN	Relationship	Primary Care Physician	PCP ID #

Please complete the following:

1. After you are enrolled in PPK, will you or any person listed above be covered by other health insurance? ☐ No ☐ Yes If yes, what insurance? _____

   Insurance Company's Phone Number: _____ Policyholder's I.D. # _____

   Policyholder's Name and Date of Birth: _____ Names of those covered: _____

2. Is a dependent child listed above mentally or physically disabled? ☐ No ☐ Yes (call PHS to obtain form) If yes, name of child? _____

3. I hereby apply for enrollment for the individual(s) listed above. I understand and accept that covered services will only be provided by the specific health care providers and institutions authorized by Preferred Plus of Kansas, Inc. subject to the terms of the employer group agreement contract. I authorize my employer to deduct from my earnings my contribution to the premium. I hereby consent to the release of information or medical records concerning services or supplies provided to me or my covered dependents by any health care provider, allied health professional, hospital or medical care institution to PPK, or its designee for the purpose of quality or utilization review or payment of a claim. A copy of this consent is available upon request. The consent is valid for the duration of the coverage. I represent that the information I have provided on this form is correct and that I do hereby agree to the terms and conditions set out in the plan.

Employee's Signature (required): _____ **Date:** _____

EMPLOYER: COMPLETE THE SECTION BELOW IN FULL, SIGN AND DATE - ALL INFORMATION IS REQUIRED (completed form may be faxed to: 316-609-2327)

Check One and Furnish Dates: ☐ Date of Employment of New Hire: _____ ☐ Open Enrollment ☐ Loss of Other Group Coverage, Date of Loss: _____

☐ Other, List Reason (e.g. family status change, PT to FT): _____ Date of Qualifying Event: _____

Effective Date of Coverage: _____ **Employer's Signature:** _____ **Date:** _____

Preferred Plus of Kansas, Inc. • P.O. Box 49288, Wichita, KS 67201-9288 • 316-609-2390 • Outside Wichita 1-800-660-8114 • Fax 316-609-2327