AZ Dependent Addition Form

IA

AMERICAN COMMUNITY
MUTUAL INSURANCE COMPANY®
39201 Seven Mile Road, Livonia, Michigan 48152-1094
FAX (734) 853-3276

Employer Name	Group Number	Certificate Number
Employee Name	Phone	Requested Effective Date:

Please check reason for addition:

- ☐Open Enrollment
- ☐Loss of Coverage
- ☐Marriage-Date of marriage__________________
- ☐Adoption-Date of Adoption ________________
- ☐Birth-Date of Birth_________________________
- ☐Other (Please Explain):______________________
- ☐Loss of Coverage under Medicaid/CHIP-Date of Loss_________________________
- ☐Determined Eligible for Medicaid/CHIP Subsidy-Date of determination_________________________

Note: For additions due to birth, adoption or marriage, please attach marriage license, birth certificate or adoption papers.

If Special Enrollment is due to loss of coverage under Medicaid/CHIP choose effective date:

☐ Date of loss of coverage under Medicaid/CHIP or ☐ 1st of the month following date of application

Dependent Information

List below all who are applying for coverage:

Relationship	Name (First, MI, Last)	SSN:	Sex	Birth Date	Coverages Applying for	Home Office Use Pre-Ex
Spouse			M F		☐ Medical ☐ Dental ☐ Vision	
Child			M F		☐ Medical ☐ Dental ☐ Vision	
Child			M F		☐ Medical ☐ Dental ☐ Vision	
Child			M F		☐ Medical ☐ Dental ☐ Vision	

Previous Coverage

If your dependent has a "Certificate of Creditable Coverage" from their prior plan or insurer you MUST include it with this application.

Within the last 18 months, did your dependents listed above have health insurance coverage? ☐Yes ☐No

If yes, who was covered? ______________________________ Insurance Company Name:_______________________________

Phone#: ___________________ Policy _____________________ Effective Date_____________ End Date_______________

Home Office Use Only			
Endorsement	TA LE LOSS CLAPP MEDS DOH________________________ Waiting Period _______________ App Signed__________________ Issue State__________________	LF/AD_________________ Dependent Life WI___________________	Medical RX M/O None S C P F Dental None S C P F VS/EX only None S C P F
Group #	Certificate #		Effective Date

Consent: I consent to any physician, hospital, clinic, pharmacy, other medical or medically related facility, insurance company, health information repository to give to American Community, its legal representatives or its reinsurers, any information, record or knowledge of the health of any persons proposed for insurance to carry out treatment, payment or health care operations. This consent includes information about drug and alcohol abuse and psychiatric conditions but does not provide for the release of psychotherapy notes. I consent to any consumer reporting agency that has any record, public record or knowledge of the character, general reputation, personal characteristics and mode of living, of any persons proposed for insurance to give to American Community, its legal representatives or its reinsurers any such record or knowledge for purposes of underwriting insurance. This consent does not allow a consumer reporting agency to release health information. A photographic copy of this consent shall be as valid as the original for 24 months from the date below. I know that I, or my authorized representative may request and am entitled to receive a copy of this consent. I know that I have the right to revoke this consent by notifying American Community in writing, except to the extent that American Community has taken action in reliance on this authorization.

I acknowledge that I have been provided with a Notice of Your Privacy Rights, which provides a complete description of how my protected health information may be used or disclosed.

Contribution: I am aware that I am required to contribute toward the cost of my insurance premium as indicated by my employer. I authorize my employer to deduct my portion of the premium for this insurance from my pay.

Disclosures: I understand no insurance exists unless and until my employer received notification in writing from American Community's Home Office indicating coverage for my dependents and the effective date. If, prior to such notification, anyone applying for coverage under this application consults a doctor, is hospitalized or has a change in health, I agree to inform American Community immediately. I understand that the agent does not have the authority to vary or waive any of the provisions of this application nor any provisions, terms or conditions of any other forms or materials supplied by American Community, nor bind American Community to any promise of coverage.

Representations

I represent that all statements and answers are true and complete to the best of my knowledge. I understand and agree that omissions, misrepresentation or misstatements may be used to deny a claim or terminate coverage if such information materially affects the degree of risk. **Any person who, with intent to defraud, submits an application or files a claim containing a false statement may be guilty of insurance fraud.**

Signature of Key Applicant or personal representative	Relationship to applicant or representative's authority to act for applicant	Date	Signed at: City and State