

EMPLOYMENT AND COVERAGE INFORMATION					
NAME OF EMPLOYER	GROUP #	TYPE OF COVERAGE	BENEFIT PLAN SELECTED	EFFECTIVE DATE	IS THIS A LATE ENROLLMENT*
		<input type="checkbox"/> SINGLE MEDICAL <input type="checkbox"/> FAMILY MEDICAL <input type="checkbox"/> SINGLE DENTAL <input type="checkbox"/> FAMILY DENTAL <input type="checkbox"/> SINGLE COBRA <input type="checkbox"/> FAMILY COBRA <input type="checkbox"/> OTHER _____	<input type="checkbox"/> STANDARD <input type="checkbox"/> PCN/PPO <input type="checkbox"/> PCN <input type="checkbox"/> PPO		<input type="checkbox"/> YES <input type="checkbox"/> NO

EMPLOYEE INFORMATION										FOR EMPLOYER USE ONLY		
LAST NAME	FIRST NAME	M.I.	BIRTH DATE			SEX M/F	DATE OF HIRE			SOCIAL SECURITY NUMBER	SELECTED PCN PHYSICIAN*	PREEXISTING CONDITIONS EXCLUSION PERIOD EXPIRATION DATE
			MO.	DAY	YR.		MO.	DAY	YR.			

Are you a current, active employee? Yes No If No, retirement date: _____

CURRENT MAILING ADDRESS				
STREET OR P.O. BOX	CITY	STATE	ZIP CODE	COUNTY

COMPLETE FOR FAMILY COVERAGES ONLY:												
EMPLOYEE AND SPOUSE <input type="checkbox"/>			EMPLOYEE AND CHILDREN <input type="checkbox"/>				EMPLOYEE AND FAMILY <input type="checkbox"/>					
LAST NAME	FIRST NAME	M.I.	DEPENDENT SOCIAL SECURITY NO.	BIRTH DATE			SEX M/F	RELATIONSHIP TO EMPLOYEE	**FULL- TIME STUDENT	HANDI- CAPPED	SELECTED PCN PHYSICIAN*	PREEXISTING CONDITIONS EXCLUSION PERIOD EXPIRATION DATE
				MO.	DAY	YR.						

**NAME OF ACCREDITED COLLEGE OR UNIVERSITY _____ SEMESTER FOR WHICH STUDENT IS ENROLLED _____ NUMBER OF HOURS ENROLLED PER SEMESTER _____

OTHER INSURANCE INFORMATION	
Spouse's Employer: _____ Spouse's Date of Birth: _____	Do you or any member of your family have other health/dental insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Medicare <input type="checkbox"/> Blue Cross/Blue Shield If Medicare, reason for coverage: <input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled <input type="checkbox"/> Kidney Disease Medicare effective date: _____
If yes, please indicate: Policy Holder _____ Policy # _____ Insurance Co. Name _____ Insurance Co. Address _____	Type of Coverage: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Single <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Family

IMPORTANT: ALL APPLICATIONS MUST BE SIGNED

PLEASE SIGN BELOW:
 I hereby authorize any providers 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. I also release to US Able Administrators any and all information relative to Title XVIII Medical Claims, or claims with other benefit plans or insurance companies, by or on behalf of me or any covered member of my family, in order to coordinate benefits with this plan.

If you are enrolling in a PCN program:
 I have read and understand the material provided explaining The Primary Care Network and have elected to enroll in this program. I understand that no PCN services (except life threatening or unless otherwise specified by your plan document) will be covered without being authorized by the Primary Care Physician listed on this application for myself and any eligible family members. I further recognize that I have the right to voluntarily change primary care physicians participating in The Primary Care Network without losing the additional benefits available under this program. I understand that should I, or a family member covered under my contract, fail to adhere to the provisions of the Primary Care Network Program, I could be forced to return to the standard benefits program offered through my employer or be forced to encounter additional out-of-pocket expense due to reduced benefit payment.
 I further authorize payment direct to my primary care physician, referred physician, hospital or other medical provider for the medical benefits otherwise payable to me.
 I understand that all determinations affecting the quality of medical care will be solely between myself and my physicians.

EMPLOYEE SIGNATURE _____ EMPLOYER SIGNATURE _____ *ENROLLMENT DATE _____
 USAA 21-122 (REV. 3/98)