



Subscriber Information				
Social Security Number	Student ID#	Subscriber Last Name	Subscribers First Name	MI
Street Address		City	State	Zip Code
Area Code/ Phone Number	Birth Date ____/____/____	Male or Female ____/____	Single or Married ____/____	Email Address ____@med.wayne.edu
List all Dependants to be enrolled or terminated				
Check One	Last Name	First Name	Birth Date	Social Security #
Spouse Add _____ Delete _____			____/____/____	
Dependant 1 Add _____ Delete _____			____/____/____	
Dependant 2 Add _____ Delete _____			____/____/____	
HMO SUBSCRIBERS ONLY				
	Physician Name	Physician's NPI #	Physicians Location	Seen this Physician in the last 12mo
Subscriber				Yes _____ No _____
Spouse				Yes _____ No _____
Dependant 1				Yes _____ No _____
Dependant 2				Yes _____ No _____
I have read and understand the conditions on the reverse side of this form		Check Coverage Choice, Number of Insured, and Your School Year		
Sign and Date Here	Coverage Choice	Number of Insured	Level of Training	
	PPO - 1 _____	1 - Person _____	Year 1 _____	
Enrollment Date:	PPO - 2 _____	2 - Person _____	Year 2 _____	
Cancel Date:	HMO _____	Family _____	Year 3 _____	
			Year 4 _____	

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