PIEDMONT COMMUNITY HEALTHCARE HMO, INC.

LocalSelect™

ENROLLMENT/CHANGE FORM

Option:

THIS SECTION MUST BE COMPLETED BY YOUR EMPLOYER

Employer Verification Signature _____ Date _____ Employee Only ❑

❑ ENROLLMENT ❑ TERMINATION COVERAGE ❑ CHANGE ❑ COBRA _____ ❑

❑ New Address/Telephone No. ❑ New Name: Give Previous Name _____ ❑
❑ Add Dependent(s) Family ❑

Group Number _____ Effective Date _____/_____/____ ❑ Remove Dependent(s)

EMPLOYEE INFORMATION

LAST NAME	FIRST	MIDDLE INIT.		SOCIAL SECURITY NUMBER
ADDRESS				EMPLOYER
CITY		STATE	ZIP	DEPT./LOCATION
HOME PHONE NO.	WORK PHONE NO.	MARITAL STATUS ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ SEPARATED		DATE EMPLOYED

INSTRUCTIONS: TO ENROLL IN PIEDMONT, YOU MUST COMPLETE THE FOLLOWING SECTION. PLEASE INDICATE A PRIMARY CARE PHYSICIAN SELECTED FROM THE PIEDMONT DIRECTORY OF HEALTH CARE PROVIDERS FOR EACH FAMILY MEMBER LISTED. IF YOU ARE ADDING NEWLY ELIGIBLE DEPENDENT(S), YOU NEED ONLY LIST THE DEPENDENT(S) YOU ARE ADDING AT THIS TIME.

SUBSCRIBER AND DEPENDENT INFORMATION (Include only those dependents to be covered by PCHC)

LAST NAME FIRST MIDDLE INITIAL	DATE OF BIRTH (MO/DAY/YR)	SEX	SOCIAL SECURITY NUMBER	CHOICE OF PRIMARY CARE PHYSICIAN
SUBSCRIBER				
SPOUSE				
DEPENDENT CHILD				
DEPENDENT CHILD				
DEPENDENT CHILD				
DEPENDENT CHILD				

ARE YOU OR ANY FAMILY MEMBER(S) LISTED ABOVE COVERED BY ANOTHER HEALTH CARE PLAN WHILE ENROLLED IN PCHC? ❑ YES ❑ NO
IF YOU ANSWERED YES, PLEASE COMPLETE THE FOLLOWING: TYPE OF COVERAGE: ❑ HEALTH ❑ DENTAL ❑ OTHER

NAME OF OTHER INSURANCE COMPANY OR PLAN PROVIDING COVERAGE:	POLICY (OR CONTRACT) NUMBER

IF ADDING DEPENDENT(S), PLEASE INDICATE REASON:
❑ MARRIAGE: DATE _____ / _____/ _____ ❑ NEWBORN ❑ ADOPTION ❑ CHANGE IN CUSTODY (SUPPORTING DOCUMENT MUST BE ATTACHED.)

COVERAGE TERMINATION

❑ REMOVE THE FOLLOWING DEPENDENT(S) ❑ TERMINATE COVERAGE: LAST DATE OF EMPLOYMENT _____ / _____ /_____

LAST NAME FIRST MIDDLE INIT.
SPOUSE
DEPENDENT CHILD
DEPENDENT CHILD

INDICATE REASON:

❑ RETIRED ❑ CHANGED EMPLOYMENT ❑ NO LONGER ELIGIBLE
❑ VOLUNTARILY WAIVED COVERAGE ❑ MOVED FROM AREA ❑ OBTAINED OTHER INSURANCE
❑ TRANSFERRING TO ANOTHER PLAN ❑ DECEASED ❑ OPEN ENROLLMENT
❑ NON-PAYMENT ❑ OTHER

I hereby apply for membership or request a change in membership in my coverage. I understand that my enrollment and benefits are in accordance with those described in the Piedmont Community HealthCare HMO ("Piedmont") Evidence of Coverage. I authorize 1) all health providers and insurers to furnish to Piedmont and 2) all health providers and Piedmont to furnish to all insurers and health providers medical-record information, including names and addresses, concerning me or any member of my family for whom information is requested for any purpose required in connection with a claim for benefits including, but not limited to, the coordination of payments with other insurers or in connection with the provision of medical care. "Medical-record information" is personal information that: (1) relates to an individual's physical or mental condition, medical history, or medical treatment; and (2) is obtained from a medical professional or medical-care institution, from the individual, or from the individual's spouse, parent, or legal guardian. I understand that I or my authorized representative is entitled to receive a copy of this form containing this authorization for disclosure of information. A photographic copy of this authorization shall be as valid as the original. I authorize my employer to deduct from my wages the amount required (if any) to cover my contribution for coverage. I certify that all of the above information is correct. I understand that the purpose of this authorization is only for coverage in connection with claims for benefits and that this authorization is valid for the duration of my coverage for health benefits with Piedmont if used in connection with a claim for benefits under the policy, or no longer than 30 months from the date this authorization is signed, if used in connection with my request for an insurance policy, reinstatement, or my request to change my policy.

SUBSCRIBER'S SIGNATURE _____ **DATE** _____

Notice of Insurance Information Practices

1. Personal information may be collected from persons other than the individual(s) proposed for coverage. This includes any information that would be considered "personal information" under Virginia state insurance law. "Personal information" includes an individual's name and address, certain other information allowed under state law, and "medical-record information," but does not include (a) information protected by the attorney-client privilege, or (b) any information that is publicly available. "Medical-record information" is any information that: (1) relates to an individual's physical or mental condition, medical history, or medical treatment; and (2) is obtained from a medical professional or medical-care institution, from the individual, or from the individual's spouse, parent, or legal guardian.
2. The purpose for collecting this information is (a) to handle an application for an insurance policy, a policy reinstatement, or a request for change in policy benefits, or (b) to determine an individual's eligibility for an insurance coverage or a claim for benefits or payment under an insurance policy.
3. This authorization to collect insurance information and personal information will last (a) for 30 months from the date it is signed, if the information is collected in connection with an application for an insurance policy, a policy reinstatement, or a request for change in policy benefits; or (b) for the duration of coverage under the policy, if the information is collected in connection with a claim for benefits under the insurance policy.
4. This information described above, as well as other personal or privileged information collected later by us or our agent, may, in certain circumstances, be disclosed to third parties without authorization.
5. Except in limited circumstances, you may access the personal health information that we have collected about you. You also have the right to have us correct or amend your protected health information to the extent and in the manner provided for by law.
6. Upon request, we will furnish a more complete explanation of our privacy and insurance information practices. To receive a copy of this explanation, please contact us at the address below, or call us at 1-800-400-7247.

Notice of Financial Information Collection and Disclosure Practices

1. Financial information collected or received in connection with an insurance transaction may, in certain circumstances, be disclosed to third parties. This includes any information that would be considered "financial information" under Virginia state insurance law. "Financial information" means any personal information other than medical record information or records of payment for the provision of health care to an individual.
2. The purpose for collecting this information is (a) to handle an application for an insurance policy, a policy reinstatement, or a request for change in policy benefits, or (b) to determine an individual's eligibility for an insurance coverage or a claim for benefits or payment under an insurance policy.
3. This authorization to collect insurance information and personal information will last (a) for 30 months from the date it is signed, if the information is collected in connection with an application for an insurance policy, a policy reinstatement, or a request for change in policy benefits; or (b) for the duration of coverage under the policy, if the information is collected in connection with a claim for benefits under the insurance policy.
4. You may request that we not disclose your protected health information to third parties. We will consider whether (a) disclosure is necessary for treatment, payment or business operations (among other permitted reasons) or required under applicable law; and (b) we can reasonably accommodate the request. Your right to request additional restrictions may be exercised at any time, and the resulting prohibition against disclosure (if and when approved) will remain in effect until it is revoked.
5. Any business associate of ours to whom personal health information is disclosed may not disclose the information to any other person except to the extent that disclosure is required or permitted under applicable law.
6. To request that personal health information not be disclosed to third parties, the individual to whom the information pertains should send a signed letter to that effect, postage pre-paid, to us at the following address:

Piedmont Community HealthCare HMO, Inc.
ATTN: Privacy Coordinator
2316 Atherholt Road
Lynchburg, Virginia 24501