THE PAINTING INDUSTRY INSURANCE FUND

8257 DOW CIRCLE
440 260 0615

STRONGSVILLE, OH 44136
GROUP ID:

OFFICE USE
ID #

ENROLLMENT FORM

SS#	LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH	SEX
					☐ MALE ☐ FEMALE

ADDRESS	CITY/STATE	ZIP

MARITAL STATUS	SPOUSE NAME	MARRIAGE DATE	SPOUSE DATE OF BIRTH	SPOUSE SS#
SINGLE ☐ MARRIED ☐ DIVORCED ☐				

DOES YOUR SPOUSE HAVE OTHER HEALTH COVERAGE? IS THERE COVERAGE AVAILABLE TO THEM? YES ☐ NO ☐

IF YES:

EMPLOYER:	EMPLOYER ADDRESS:
INSURANCE COMPANY:	POLICY NUMBER:

DEPENDENT INFORMATION

DEPENDENT NAME (PLEASE ADD LAST NAME IF DIFFERENT)	RELATIONSHIP(IE:SON/DAUTR/SPOUSE)	DATE OF BIRTH	SS#

DOES ANY DEPENDENT LISTED ABOVE HAVE OTHER HEALTH COVERAGE? IS THERE COVERAGE AVAILABLE TO THEM?

☐ **IF YES (COMPLETE BELOW):** ☐ **NO**

EMPLOYER:	EMPLOYER ADDRESS:
INSURANCE COMPANY:	POLICY NUMBER:

MEDICARE INFORMATION

ARE YOU ENROLLED IN MEDICARE? ☐ YES ☐ NO	ANY DEPENDENT ENROLLED IN MEDICARE ☐ YES ☐ NO
IF YES:	NAME:
ENROLLED IN HOSPITAL (PART A) MEDICARE? ☐ YES ☐ NO	ENROLLED IN HOSPITAL (PART A) MEDICARE? ☐ YES ☐ NO
ENROLLED IN MEDICAL (PART B) MEDICARE? ☐ YES ☐ NO	ENROLLED IN MEDICAL (PART B) MEDICARE? ☐ YES ☐ NO
MEDICARE CLAIM NUMBER:	MEDICARE CLAIM NUMBER:

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I HAVE READ, UNDERSTAND AND AGREE TO THE AUTHORIZATION FOR RELEASE OF INFORMATION AS SHOWN BELOW.

SIGNATURE OF EMPLOYEE: **DATE SIGNED:**

SIGNATURE OF BENEFITS REPRESENTATIVE DATE SIGNED:

AUTHORIZATION

I HEREBY AUTHORIZE AND DIRECT ALL PHYSICIANS AND OTHER HEALTH CARE PROFESSIONALS, HOSPITALS, CLINICS, DISPENSARIES, SANITARIUMS, DRUGGISTS AND ALL OTHER AGENCIES (INCLUDING INSURANCE COMPANIES, HEALTH SERVICE ASSOCIATIONS AND THIRD PARTY PAYERS) AND ANY OTHER HOLDER OF MEDICAL INFORMATION ABOUT ME OR ANY INDIVIDUAL RECEIVING COVERAGE PURSUANT TO MY ENROLLMENT HEREIN TO PERMIT MEDICAL MUTUAL, THE MEMBER PREFERRED PROVIDER ORGANIZATIONS OF MEDICAL MUTUAL AND ANY MEDICAL ADVISORY COMMITTEES, OR ANY DESIGNEE OF ANY OF THESE ORGANIZATIONS APPOINTED FOR THE PURPOSES OF CLAIMS MANAGEMENT, AUDIT, STATISTICAL ANALYSIS OR UTILIZATION REVIEW, TO OBTAIN OR VIEW OUR RECORDS PERTAINING TO ANY OF OUR MEDICAL HISTORY OR ANY EXAMINATION, TREATMENT OR PRESCRIPTIONS THAT ANY OF US HAVE RECEIVED, ARE RECEIVING OR WILL RECEIVE OR ANY MEDICAL EXPENSES THAT ANY OF US HAVE INCURRED, ARE INCURRING, OR WILL INCUR DURING OUR ENROLLMENT IN MEDICAL MUTUAL, INCLUDING BUT NOT LIMITED TO THE USE OF SUCH INFORMATION FOR PREADMISSION, CONCURRENT AND RETROSPECTIVE UTILIZATION REVIEW.

I HEREBY REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF TO THE PROVIDER OF HEALTH CARE SERVICES FOR ANY SUCH SERVICES FURNISHED BY THAT PROVIDER, UNLESS I DESIGNATE OTHERWISE IN WRITING TO MEDICAL MUTUAL OR ANY MEMBER PREFERRED PROVIDER ORGANIZATION OR ANY SUCH PROVIDER OF SERVICES.

I HEREBY REPRESENT THAT I AM THE LEGAL GUARDIAN OF ANY DEPENDENTS COVERED HEREIN WHO ARE UNDER 18 YEARS OF AGE AND THAT I HAVE THE CONSENT OF EACH INDIVIDUAL COVERED HEREIN WHO HAS ATTAINED THE AGE OF 18 OR OVER TO AUTHORIZE THE RELEASE OF THE ABOVE INFORMATION.