CHP Enrollment Form

Effective Date: __ / 1 / 2021

Member Information (Please Print Clearly in ink or type)		
First Name:	Middle Initial:	Last Name:
Address:		
City, State, Zip:		
Social Security Number:		Medicare ID Number (on Medicare Card):
Sex: ☐ M ☐ F		Birth Date:
Phone Number:		Email Address:

Spouse Information (Please print clearly in ink or type only if enrolling spouse in coverage)		
First Name:	Middle Initial:	Last Name:
Sex: ☐ M ☐ F	Birth Date:	Medicare ID Number (on Medicare Card):
Social Security Number:		Email Address:

Plan Selection - Member and Spouse must elect the same plan.	
CHECK DESIRED COVERAGE:	**ADVANTAGE OPTION**
MEMBER	
SPOUSE	

Dental/Vision Plan Selection (You must enroll in a CHP Group Plan Option to be eligible for dental or vision coverage.)			
CHECK DESIRED	**DENTAL PROGRAM**	**VISION PROGRAM**	**I/WE DECLINE THIS COVERAGE**
MEMBER			
SPOUSE			

Please Complete the Following Information:
Do you currently have any Medicare Supplement policies or Medicare Advantage Policies in force (other than the current CHP coverage)? Member (if enrolling): ☐Yes ☐No Spouse (if enrolling): ☐Yes ☐No
If YES, with which company?

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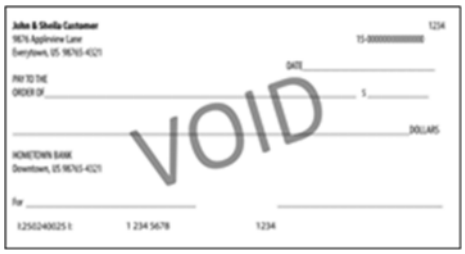
ATTESTATION	
Please be sure to sign, date and return this completed Enrollment Form along with a check for the first monthly payment* to: **AmWINS/Concordia Health Plan, 50 Whitecap Drive, North Kingstown, RI 02852**	
Member Signature:	**Date:**
Spouse Signature:	**Date:**

ACH AUTHORIZATION		
Name (Last, First, Middle Initial)**:**		
Street Address:		
City:	**State:**	**Zip:**
Type of Account: **☐Savings ☐ Checking**		**Select Monthly Withdrawal Date:** **☐1st ☐ 8th ☐ 15th**

Please ensure the following:

☐ To deduct monthly from your **checking account**; A **VOIDED** check must accompany this signed authorization *(starter checks are not accepted).*



☐ To deduct monthly from your **savings account**; A signed letter from your banking institution must accompany this signed authorization.

Monthly payments are withdrawn on the first business day on or after the date you selected above. You will receive a confirmation from AmWINS Group Benefits that we have set up your account information to withdraw from your designated bank account. ***Note:*** Your monthly deduction will show as **AmWINS** on your bank statement.

I authorize AmWINS to withdraw payment from my checking or savings account according to my agreed payment schedule. This authorization is to remain in force until AmWINS has received written notification from me of its termination in such time and manner as to afford AmWINS a reasonable opportunity to act on the request. If my account is erroneously charged, my financial institution will immediately credit the same amount to the account up to 15 days following issuance of the statement or 45 days after the erroneous posting, whichever occurs first.

Signature:	**Date:**

***** Regardless of payment method elected, please return this completed form with a check for your first monthly payment.