

HealthAmerica Advantra Enrollment Department:

This is confirmation that I wish to be enrolled in HealthAmerica Advantra for my health care and prescription coverage and did not make a request to disenroll from this plan. I would like for my coverage to be effective on January 1, 2009.

Name\_\_\_\_\_

Signature\_\_\_\_\_

Date of Birth\_\_\_\_\_

Social Security Number\_\_\_\_\_

Date\_\_\_\_\_

Please return in the postage paid envelope to :  
Advantra Enrollment Department  
P.O. Box 67103  
Harrisburg, PA 17106-7103

You may also fax this request to:  
Advantra Enrollment Department  
717-671-5240

If you have any questions or need assistance in completing this form, please contact Advantra Customer Service at 1-800-290-0190 (TTY/TDD 1-800-207-1261).