GROUP ENROLLMENT FORM

COMPLETE IN INK, INCOMPLETE AREAS MAY DELAY PROCESSING

GROUP

PLAN

NAME OF EMPLOYER | EMPLOYER ADDRESS | CITY | STATE | ZIP

FULL NAME OF EMPLOYEE (LAST,FIRST, MIDDLE) | EMPLOYEE ADDRESS/CITY, STATE, ZIP

DATE OF FULL TIME EMPLOYMENT | OCCUPATION OR TITLE | SOCIAL SECURITY NUMBER | DATE OF BIRTH Mo. Day Yr.

Do you work for this employer at least 30 hours each week? YES ☐ NO ☐

WEEKLY EARNINGS/CLASS

MARITAL STATUS ☐ married ☐ single

SEX ☐ male ☐ female

PHONE

EMAIL

MEDICAL COVERAGE REQUESTED

Employee Only ☐ (if offered) Employee and Child ☐ (if offered) Employee and Spouse ☐ Family ☐ Life Only ☐ Declining Medical Coverage ☐

BENEFICIARY NAME

RELATIONSHIP

DENTAL COVERAGE REQUESTED

Employee Only ☐ (if offered) Employee and Child ☐ (if offered) Employee and Spouse ☐ Family ☐ Life Only ☐ Declining Dental Coverage ☐

IF DECLINING COVERAGE, PROVIDE REASON FOR DECLINING: ☐ Covered under spouse's employer's group plan

☐ **Other (explain)**

If insurance is refused because of coverage under a spouse's employer's group plan, please indicate name of insurance company providing coverage:

SPOUSE'S NAME (if to be covered) | DATE OF BIRTH | SPOUSE'S EMPLOYER | SPOUSE'S SOC. SEC. #

DEPENDENT CHILDREN NAME (if to be covered)	DATE OF BIRTH	DEPENDENT CHILDREN SOC. SEC. #	AGE	SEX

(If additional space is needed for dependents, please include the appropriate information on a separate sheet of paper and attach to this form.

ARE YOU, YOUR SPOUSE, OR CHILDREN INSURED UNDER ANY OTHER PLAN OF INSURANCE? Yes ☐ No ☐

If "Yes" complete the following:

A. Is this other insurance through an employer of U.S. Government Yes ☐ No ☐ If "yes" complete (a)

(a) Employer's Name or Government Service _____

B. Group or Policy No. _____ Contract No. _____

C. Indicate which member of family is covered: ☐ Self ☐ Spouse ☐ Children

D. Name and address of Insurance Company _____

I hereby apply for or decline group insurance as designated above and if I am applying for group insurance, authorize payroll deductions for my share, if any, of the cost of the coverages applied for. I certify that all the information on this form is complete and true. I understand that my coverage, if approved, and that of my dependents, if any, age 19 and older, may be subject to the pre-existing con-dition provision and that this provision has been fully explained to me.

I REPRESENT that all of the statements contained in this application are true and correct and that no material information has been intentionally withheld or omitted. I understand that the answers to the questions contained in this application shall be the basis of any coverage issued and that if any material information is intentionally misrepresented or fraudulent omitted from the application, it could provide the basis for the Employer to refuse coverage and to refund all my contributions as though my coverage had never been in force.

If I am declining coverage, I confirm that I have been given the opportunity to apply for coverage in the group plan provided by my employer. The benefits have been thoroughly explained to me. After serious consideration, I have decided not to take advantage of this offer.

SIGNATURE OF EMPLOYEE	DATE	CREDITABLE COVERAGE ☐ YES ☐ NO IF YES, NUMBER OF MONTHS

STATEMENT OF RIGHTS (TO BE SIGNED BY ALL EMPLOYEES)

I have been advised of my rights to demonstrate any creditable coverage, my rights to request a Certificate of Creditable Coverage from my prior plan, the fact that this Plan will assist me in obtaining a Certificate from my prior plan and the terms of this Plan's Pre-existing Conditions.

I understand that if I am declining enrollment for myself or my dependents (including my spouse) because of other health insurance coverage. I may in the future be able to enroll myself or my dependents in this Plan, provided that I request enrollment within 30 days after the other coverage ends. In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

SIGNATURE	DATE

EMPLOYER – COMPLETE THE FOLLOWING

Check One: ☐ New Employee ☐ Change ☐ Cancellation	Effective Date or Cancellation Date

Changes *(Check Appropriate Boxes)*

☐ Add Dependent
☐ Address Change
☐ Name Change
☐ Reinstatement Of Coverage
☐ Cancel All Coverage
☐ Cancel All Dependents
☐ Cancel Named Dependent(s) only (As Shown Above)
☐ Marriage ☐ Divorce ☐ Legal Separation ☐ Age Limit
☐ Other _____