ENROLLMENT FORM

SECTION 1 - BENEFIT INFORMATION

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legal Separation

Employment Information

Name of Employer: ______________________________

Date of Hire: ______________________________

Hours Worked/week: ______________________________

Job Title: ______________________________

Division/Location: ______________________________

SECTION 2 - EMPLOYEE AND FAMILY INFORMATION (list all family members to be covered)

Employee Last Name	First	MI	Birthdate	Gender

Employee's Address	City	State	Zip

Home Phone	Work Phone	Social Security Number

Spouse Last Name	First	MI		Birthdate	Gender
Social Security Number					

Dependent's Last Name	First	MI	Relationship	Birthdate	Gender
Social Security Number					
Dependent's Last Name	**First**	**MI**	**Relationship**	**Birthdate**	**Gender**
Social Security Number					
Dependent's Last Name	**First**	**MI**	**Relationship**	**Birthdate**	**Gender**
Social Security Number					
Dependent's Last Name	**First**	**MI**	**Relationship**	**Birthdate**	**Gender**
Social Security Number					

* Relationship refers to son, daughter or step child.

Your Plan may have a preexisting exclusion period. A preexisting period must be reduced by any prior creditable health coverage you and/or your dependent(s) may have had as long as there was less than a 63 day break in coverage. You have the right to provide evidence of prior coverage. Check with your employee benefits administrator for details.

TO ACCEPT COVERAGE PLEASE COMPLETE AND SIGN THE REVERSE SIDE

I DECLINE: Complete this section ONLY if declining coverage for self and/or eligible dependents

Declining Coverage For:	☐ Self ☐ Spouse ☐ Dependent(s)	Reason: ☐ Other Group Coverage ☐ Individual Coverage ☐ Other

The available coverages have been explained to me by my employer. I have been given the chance to apply for the available coverages. I have decided not to enroll myself and/or my spouse/dependent(s). By declining coverage, I acknowledge that my spouse, dependent(s), and I may have to wait to be enrolled until the next Open Enrollment period or qualifying event.

Employee Signature (only if declining coverage, if signed in error, please cross out and initial)	Date

To help reduce the cost of health care, your healthcare coverage includes a Coordination of Benefits provision. In order for us to process your claim(s), we need the following information to determine the primary carrier as prescribed by law. We routinely investigate to update our records.

OTHER INSURANCE INFORMATION

If you or any family members listed on this application have Medicare, is coverage: □ Part A □ Part B

Member	Effective Date	Medicare Number	Reason for Medicare Entitlement

Are you or any family members covered by Medicare disability? □ NO □ YES - □ Part A □ Part B

Do you or any family members listed on this application, have □ group or □ individual coverage not listed above?

Medical Coverage	□ NO □ YES	Dental Coverage	□ NO □ YES
Prescription Coverage	□ NO □ YES	Orthodontia	□ NO □ YES
Vision Coverage	□ NO □ YES		

If the answer to any of the above questions is "Yes.", please complete the section below. If you have more than one policy, please provide this information on a separate sheet.

Name of Policyholder with other coverage	Relationship	Policyholder's Birth date	Name of other group insurance plan	Phone Number

Address of Other Coverage	City	State	Zip Code

This coverage is for:	Group ID Number	Member ID Number
□ Medical □ Rx □ Dental □ Vision		

This plan covers:

□ Self □ Spouse □ Child(ren) □ Stepchild(ren) □ Other

Please list Names:

Name of Employer:		Effective Date	Termination Date
	□ Active □Retiree □ Continuation		

When parents are divorced or legally separated, insurance regulations stipulate which health plan carrier will be primary for dependent child(ren). The carrier covering the person with custody of the child(ren) or the person who was given financial responsibility for the health expenses of the child(ren) by a court decree is primary.

CHILD CUSTODY INFORMATION

If you and your spouse are divorced or legally separated, please indicate below who has legal custody of your child(ren).

Name of Child(ren)	Father	Mother	Joint	Other	Date Awarded	Has the parent without custody been required by court decree to provide coverage for the dependent child(ren)? YES	NO
____________	□	□	□	□	____________	□	□
____________	□	□	□	□	____________	□	□
____________	□	□	□	□	____________	□	□

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time for the purpose of facilitating healthcare treatment, payment or for the purpose of business operations necessary to administer healthcare benefits; or as required by law.

Health Information requested or disclosed may be related to treatment or services performed by:

- a physician, dentist, pharmacist or other physical or behavioral healthcare practitioner;
- a clinic, hospital, long-term care or other medical facility;
- any other institution providing care, treatment, consultation, pharmaceuticals or supplies, or;
- an insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

A separate authorization will be required for psychotherapy notes. I understand that if this application contains any material misstatements or omissions, the plan may deny coverage, modify or cancel coverage and/or take any other legal action available by law.

► ______________________________ ______________ ______________________________

Applicant's Signature Date Applicant's Full Name (please print clearly)