Administered by:
Group Benefit Services, Inc.

Employer Use Only
Coverage Effective Date: ___________

EMPLOYEE ENROLLMENT FORM

Self-Funded Medical Coverage for **Small Groups Under 51 Lives**

Applicant Social Security Number | | | | | | | | | | |

Group Number | | | | | | | | | | |

APPLICANT INFORMATION

Employer Name:_______________________________________ Employer Location (if more than one) ____

Last Name												First Name										Initial

☐ Single ☐ Married	Address	City	State	Zip	County
Home Phone #	_ _ _ — _ _ _ — _ _ _ _	Gender ☐ M ☐ F	Date of Birth / /	Height	Weight
Date Employed Full Time / /	Average Hours Worked Per Week:	Annual Salary $	Occupation Are you an independent contractor? ☐ Y ☐ N		

WAIVER (Please complete if you are declining medical coverage)

Please check all of the following that apply: I waive medical coverage for: ☐ Employee ☐ Spouse ☐ Child(ren)	Please state reason for waiving coverage:__________________________ Qualifying Coverage ________________ Other ___________________

If I have waived coverage for myself and/or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself and/or my dependents in the coverage, provided that I request enrollment within 31 days after my other coverage ends because of involuntary loss of other coverage (divorce, death, legal separation, termination of employment, reduction in number of hours of employment). 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 my dependents, provided that I request enrollment within 31 days after the date of the event. I further understand that if I am considered a late enrollee, I may be declined from coverage, excluded from coverage for a period of time, or subject to pre-existing condition limitations as defined in and where permitted by law, and I may be required to provide, where allowed by law, Medical History satisfactory to the Plan Sponsor or Administrator, for myself and/or my dependents. I further understand that if this form is submitted after the enrollment period, and I am approved for coverage, a longer limitation may apply to pre-existing conditions disclosed herein.

FAMILY INFORMATION (Only for those applying)

First Name & M. I. (last name if different)	Gender	Date of Birth	Height	Weight	Social Security No.	Primary Care Physician's Name
Spouse:	☐ M ☐ F	/ /			/ /	
Child:	☐ M ☐ F	/ /			/ /	
Child:	☐ M ☐ F	/ /			/ /	
Child:	☐ M ☐ F	/ /			/ /	
Child:	☐ M ☐ F	/ /			/ /	

Dependents (age 19 and older) attending school full-time. Include name of dependent, name/address of school, and no. of credits:___________________

____

ELIGIBLITY AND OTHER INSURANCE INFORMATION

☐ Y ☐ N Currently, are you working full-time? If no, explain ____

☐ Y ☐ N Do you or any family members intend to keep other insurance coverage in addition to this coverage? If yes, list family members:

____

List the name of the other insurance company(ies) and the policy number(s):____

List family members covered by Medicare and their effective date:____

COVERAGE AND CHANGE REQUEST INFORMATION

☐ Employee ☐ Family ☐ Employee/Spouse ☐ Employee/Child(ren)

Name of medical plan you have selected: ____

PPO Network Name: ____

Change Request: ☐ Marriage ☐ Divorce ☐ Adoption ☐ Returning to school full-time

☐ Court Order Date of Event (you may be required to provide proof of the event): _____/______/_____

Attach a written and signed statement by the employer for a requested coverage effective date. Effective date may not be guaranteed.

REQUIRED MEDICAL INFORMATION

1. ☐ Y ☐ N Are you or any dependent disabled, hospital confined, or pregnant? If pregnant, due date: ____/____/____
   If pregnant, are you expecting a multiple birth / having complications / planning a C-Section? ☐ Y ☐ N

2. ☐ Y ☐ N Are you or any eligible dependent receiving treatment; taking medication; receiving follow up care; scheduled for or awaiting results of any tests, biopsies, procedures or lab work; been advised to have a test; or been advised of a condition that will require attention in the next twenty-four (24) months?

3. ☐ Y ☐ N Have you or any eligible dependent used tobacco products in the past twelve (12) months?

4. ☐ Y ☐ N Have you or any eligible dependent ever been declined, postponed, ridered, or rated up for medical, disability, or life insurance with another insurance carrier? If yes, please explain.

5. ☐ Y ☐ N In the past five (5) years, have you or any eligible dependent to be insured had any symptoms, diagnosis, consultation, testing, treatment, follow up care, or taken any medication or received counseling for:

a. ☐ Yes ☐ No Cancer/Tumor
b. ☐ Yes ☐ No Kidney Disorder
c. ☐ Yes ☐ No Stroke
d. ☐ Yes ☐ No Immune System Disorder
e. ☐ Yes ☐ No Arthritis/Back/Joint Disorder
f. ☐ Yes ☐ No Diabetes
g. ☐ Yes ☐ No Liver Disorder/Hepatitis
h. ☐ Yes ☐ No Systemic Lupus/Multiple Sclerosis
i. ☐ Yes ☐ No Mental Disorder Alcohol/Drug Abuse
j. ☐ Yes ☐ No Heart/Blood/Vascular Disorder/ Hypertension
k. ☐ Yes ☐ No Birth Defects/Congenital Disorder
l. ☐ Yes ☐ No Infertility
m. ☐ Yes ☐ No Respiratory/Lung Disorder
n. ☐ Yes ☐ No Organ/Tissue Transplants
o. ☐ Yes ☐ No Neurological Disorder
p. ☐ Yes ☐ No Acquired Immune Deficiency Syndrome (AIDS)/AIDS Related Complex (ARC)/HIV

Please provide details to "Yes" answers, including information regarding last doctor visit and/or physical examination and all medications taken (attach extra pages if needed with signature and date.)

Question/Letter	Name	Illness/Impairment	Dates Treated	Medications/Treatment/Surgery/Treating Physician

PRIOR MEDICAL PLAN INFORMATION

Failure to provide the following information may result in a reduction or delay in payment of benefits. Please attach any Certificate(s) of Creditable Coverage or other similar proof of coverage you have received.

☐ Y ☐ N Have you or any dependents applying for coverage been covered by this employer's prior group medical plan?

☐ Y ☐ N Have you or any dependents applying for coverage been covered by any medical plan other than this employer's prior group medical plan?

If yes:

Insurance Company Name___________________________________ Phone # _____________________________ Policy/Group # ____________

Termination Date _________________ Effective Date ___________________ Reason for Termination _____________________________________

Who was covered? ____

TO BE A VALID APPLICATION, YOUR SIGNATURE AND THE DATE YOU SIGN IT ARE REQUIRED.
SIGNATURE REQUIRED – EMPLOYEE AGREEMENT

I understand that the previous answers will be relied upon by the Plan Sponsor in the issuance of a Summary Plan Description. I declare all statements contained in this entire form about me and my dependents are true and correct to the best of my knowledge and that no material information has been withheld or omitted. I understand that my intentional misrepresentation of a material fact or my failure to report information about me or my dependents may be used as the basis to rescind, terminate or modify coverage for me or my dependents. Rescind means that the coverage was never in effect. I understand and agree that the Plan Sponsor is not bound by any statement made by or to any agent unless written herein. I agree that no coverage will be effective until the date specified by the Plan Sponsor in the Summary Plan Description. The actual effective date may not be the requested effective date. If I am now waiving medical benefits for myself and/or my dependents, I have read the entire Waiver provision, and understand the enrollment requirements if I make request for such benefits at a later date.

To assist with determining my creditable coverage, I authorize any insurance company, third party administrator, or other carrier or provider of health benefits to release to the third party administrator and/or Plan Sponsor certificates of creditable coverage and all such information.

I authorize my employer to deduct the necessary contribution toward the benefits. I reserve the right to revoke this deduction authorization at any time upon my written notice. Benefits are effective only after approval by the Plan Sponsor or Administrator and satisfaction of any probationary period.

Any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false information may be found guilty of fraud, which is a crime, in a court of law and may be subject to fines and confinement in prison. This will not be considered as a complete application unless all pages are attached and completed.

☐ I understand that information on this application is valid for a maximum of 60 days from the date of signature.

Applicant Signature X ____ **Date (required)** ____________________________

If signed by a representative of applicant, please indicate the representative's authority to act on behalf of applicant.

____

SIGNATURE REQUIRED/AUTHORIZATION
TO RELEASE MEDICAL INFORMATION FOR ENROLLMENT

Please clearly print all information.

I hereby authorize those physicians, medical practitioners, hospital, clinics, veteran's administration facilities, medical information services, urgent care facilities, and other medical or medically related entities, insurance or reinsurance companies, and consumer reporting agencies that have information available as to the present or former physical health condition, including drug or alcohol or domestic abuse, and/or treatment of me or my dependents to release any and all such information, including, but not limited to, medical records, health care provider notes, laboratory tests and results, diagnoses, treatment, and prognoses. I understand the information obtained by use of this authorization may be used to determine eligibility for issuance of health coverage and eligibility for benefits under existing health coverage for me and my dependents. This authorization is not applicable to psychotherapy notes.

I agree that a photographic copy of this authorization shall be as valid as the original and that this authorization shall be valid for 2 ½ years from the date shown below. I understand that I may request a copy of this authorization. I understand that I may revoke this authorization at any time in writing unless action has been taken in reliance on my authorization. Because this authorization is given as a condition of obtaining coverage, my revocation will not prevent the Insurer and/or Plan Sponsor from the right to contest a claim if another law so allows. Should I refuse to sign this authorization, I understand it may affect my enrollment in the benefit plan. All pages must be attached and complete, including this authorization for the application to be considered complete. Incomplete applications may be rejected.

Applicant Signature X ____ **Date** ________________________

If signed by a representative of applicant, please indicate the representative's authority to act on behalf of applicant:

____

Applicant Email Address ____