SUBMIT THIS FORM TO HUMAN RESOURCES

ENROLLMENT OF GROUP BENEFITS

EMPLOYER USE MED. COV. TYPE	EMPLOYMENT STATUS	EFFECTIVE DATE
PPO:	☐ NEW HIRE	
HMO:	☐ REINSTATEMENT	
OO AREA:	☐ REHIRE	

GROUP NUMBER | EMPLOYER NAME | PLAN NAME

1. EMPLOYEE'S LAST NAME | FIRST NAME | MIDDLE INITIAL | 2. DOB (MM/DD/YY) | 3. EMPLOYEE SSN / MEMBER ID #

4. EMPLOYEE'S MAILING ADDRESS | CITY | STATE | ZIP | 5. PHONE NUMBER

6. SEX ☐ MALE ☐ FEMALE

7. MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ OTHER

8. DATE EMPLOYED

8. DIVISION / LOCATION

9. OCCUPATION

10. INDICATE COVERAGES ELECTED

MEDICAL	DENTAL	BASIC LIFE			
☐ EMPLOYEE	☐ CHILD(REN)	☐ EMPLOYEE	☐ CHILD(REN)	☐ EMPLOYEE	STD ☐ NO ☐ YES _____
☐ SPOUSE	☐ FAMILY	☐ SPOUSE	☐ FAMILY	☐ DEPENDENT	LTD ☐ NO ☐ YES _____
					SUPP'L LIFE ☐ NO ☐ YES _____

11. LIST DEPENDENTS TO BE COVERED:

	LAST NAME	FIRST NAME	MI	SEX	DOB	SSN
SPOUSE						
CHILD						
CHILD						
CHILD						
CHILD						
CHILD						

12. LIFE CLASS /AMOUNT

13. NAME OF BENEFICIARY* LAST FIRST MI

14. RELATIONSHIP ☐ SPOUSE ☐ CHILD(REN) ☐ PARENT ☐ OTHER

15. BIRTH DATE OF BENEFICIARY
IF UNDER 19 (MM/DD/YY)

* Unless otherwise specified, surviving beneficiaries will share equally. If there is no designated beneficiary living on the date of death of the employee, payment will be made to the estate of the employee.

16. PAY TYPE ☐ HOURLY ☐ SALARY ☐ COMMISSION

17. WAGES ANNUAL $_____ MONTHLY $ _____ WEEKLY $_____ HOURLY $_____

18. CREDITABLE COVERAGE INFORMATION

Do you or your dependents have previous creditable medical coverage under another health plan such as an employer sponsored group health plan or HMO, individual policy, Medicare Medicaid or Champus? ☐ YES ☐ NO

If YES, a copy of any certificates of creditable medical coverage may be required prior to any claims being processed under this plan.

☐ CERTIFICATE ATTACHED ☐ CERTIFICATE BEING FORWARDED

I hereby request coverage under the group policy(ies) issued by my Employer's Health Plan covering certain employees of my employer and authorize my employer to deduct from my earnings any required contributions. I am an eligible employee working the required hours per week for my employer. I understand that my election of coverages above does not automatically guarantee that coverage is in force. All eligibility requirements of the policy(ies) must be properly satisfied before coverage becomes effective.

19. EMPLOYEE'S SIGNATURE: _____ (REQUIRED) DATE: _____ (REQUIRED)

WAIVER OF GROUP BENEFITS

This is to certify that I have been given an opportunity to enroll for group insurance benefits for myself and my eligible dependents as offered by my employer, and that after careful consideration I have decided NOT to take advantage of this offer.

I also understand that if, at a later date, I desire to enroll for this coverage for myself and my eligible dependents, opportunities to join the plan will be limited according to the eligibility guidelines of my employer's employee benefit plan.

☐ **Waiver of Group Benefits - Employee Only** ☐ **Waiver of Group Benefits - Employee and Dependent**

PRINTED NAME: _____ SSN: _____

SIGNED BY: _____ DATE: _____

EMPLOYER: _____ LOCATION: _____