Crescent Health Solutions
1200 Ridgefield Blvd, Ste 215 • Asheville, NC 28806
Phone: 828-670-9145 • Fax: 828-670-9155

Group Benefits

MARION EYE CENTER & Optical

Employer

Group Number | Employer Name | Div/Dept/ Subgroup

Employee Data

Last Name | First Name | Middle Ini | DOB (MM/DD/YY) | SSN or Member ID#

Employee Mailing Address | City | State | Zip | Phone Number

Hire Date (MM/DD/YYYY) **Gender** ☐ Male ☐ Female **Marital Status** ☐ Married ☐ Single ☐ Divorced ☐ Other

Dependent Data

Dependent Type	Last Name	First Name	MI	Male	Female	Date of Birth (MM/DD/YY)	SSN
Spouse							
Child 1							
Child 2							
Child 3							
Child 4							

-------COVERAGE------- ----------BENEFIT---------- ----------ACTION----------

Person	Effective Date (MM/DD/YY)	Medical $900 PPO	Medical $1500 PPO	Medical MRP	Medical MAXI	Medical MAXI II	Medical ACP	AllyHealth	New Hire	Enroll / Add	Cancel/ Term	Change	Reason for Change
Employee		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Spouse		☐	☐	☐	☐	☐	☐			☐	☐	☐	
Child 1		☐	☐	☐	☐	☐	☐			☐	☐	☐	
Child 2		☐	☐	☐	☐	☐	☐			☐	☐	☐	
Child 3		☐	☐	☐	☐	☐	☐			☐	☐	☐	
Child 4		☐	☐	☐	☐	☐	☐			☐	☐	☐	

Other Coverage

Check if you or your Dependent(s) have other medical insurance. If yes, please attach a separate sheet with details. ☐ **Other coverage**

Mailing Address Change

Effective Date of Change | Address | City | State | Zip

Employee Name Change

From: Last Name | First Name | MI

To: Last Name | First Name | MI

Effective Date of Change | Reason for Change

Waiver of Group Benefits

I desire to waive the following benefits: (check all applicable) ☐ **Medical**

My signature indicates I hereby decline the opportunity to enroll for group insurance benefits offered by my employer for my eligible dependents and myself. After careful onsideration, 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 benefit plan.

Signature | Date

Acknowledgment

Employee's Signature | Signature - Human Resources | Date

My signature above indicates I understand my election of coverage and does not automatically guarantee that coverage is in force. All eligibility and plan document requirements must be satisfied before coverage becomes effective.