ENROLLMENT FORM

COMPANY/EMPLOYER NAME				DIVISION/LOCATION
EMPLOYEE NAME (LAST, FIRST, MIDDLE INITIAL)				SOCIAL SECURITY NUMBER
ADDRESS:STREET	CITY	STATE	ZIP	PHONE NUMBER

MEDICAL ☐ DENTAL ☐ FLEXIBLE BENEFITS ☐	ORIGINAL DATE OF COVERAGE MO DAY YEAR	DATE HIRED FULL TIME MO DAY YEAR	DATE OF BIRTH MO DAY YEAR	SEX ☐ MALE ☐ FEMALE

MARITAL STATUS: ☐ SINGLE ☐ WIDOWED ☐ MARRIED ☐ DIVORCED

STATUS: ☐ NEW EMPLOYEE ☐ REHIRED EMPLOYEE ☐ SPECIAL ENROLLEE ☐ LATE ENROLLEE ☐ OPEN ENROLLMENT

ELIGIBLE FOR MEDICARE? YES ☐ NO

OTHER COVERAGE: Coverage: ☐ Self ☐ Family — POLICY# — NAME OF INSURANCE: — EFFECTIVE DATE:

TO BE COVERED, ALL DEPENDENTS MUST BE LISTED BELOW. DEPENDENTS NOT NAMED ARE NOT COVERED. DEPENDENTS ARE NOT ELIGIBLE FOR COVERAGE NOT ELECTED BY THE EMPLOYEE. INDICATE ANY DEPENDENT CHILD IN A SCHOOL BEYOND HIGH SCHOOL OR WHO IS HANDICAPPED. NOTE: COMPLETE DENTAL BLOCK ONLY IF DENTAL IS PROVIDED IN THE PLAN. COMPLETE "ORIGINAL DATE OF COVERAGE" ONLY FOR INDIVIDUALS CURRENTLY COVERED UNDER THE EMPLOYERS MEDICAL PLAN IF PLAN IS BEING REPLACED.

SPOUSE	☐ MEDICAL ☐ DENTAL	DATE OF BIRTH MO DAY YEAR	SEX ☐ MALE ☐ FEMALE	SPOUSE SS#
IS SPOUSE EMPLOYED? ☐ YES ☐ NO	IF YES, WHERE?	DOES SPOUSE HAVE GROUP COVERAGE AVAILABLE THROUGH EMPLOYER? ☐ YES ☐ NO		IS SPOUSE COVERED UNDER SUCH PLAN? YES ☐ N ☐

DEPENDENT CHILD	☐ MEDICAL ☐ DENTAL	DATE OF BIRTH MO DAY YEAR	SEX ☐ MALE ☐ FEMALE	CHILD SS#
BEYOND HIGH SCHOOL? ☐ YES ☐ NO	HANDICAPPED? ☐ YES ☐ NO	IS DEPENDENT CHILD COVERED UNDER ANY OTHER HEALTH PLAN? ☐ YES ☐ NO		
IF YES, INDICATE NAME OF COVERED PERSON AND PLAN:				

DEPENDENT CHILD	☐ MEDICAL ☐ DENTAL	DATE OF BIRTH MO DAY YEAR	SEX ☐ MALE ☐ FEMALE	CHILD SS#
BEYOND HIGH SCHOOL? ☐ YES ☐ NO	HANDICAPPED? ☐ YES ☐ NO	IS DEPENDENT CHILD COVERED UNDER ANY OTHER HEALTH PLAN? ☐ YES ☐ NO		
IF YES, INDICATE NAME OF COVERED PERSON AND PLAN:				

LIFE INSURANCE BENEFICIARY: RELATIONSHIP:

I hereby apply for self-funded and/or Insurance coverage. The beneficiary designation supersedes all previous designations. I agree the copy of my signature or copy of this form may be accepted as my signature. I authorize necessary deductions from my salary, account or dues for any contributions required. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, Insurance company, the Medical Information Bureau, or other organization, institution or person that has any records or knowledge of me or my family's health, to give to the Insurer, including the reinsurers, such information. A photographic copy of this authorization shall be as valid as the original. I agree that, to the best of my knowledge and belief, all statements and answers to the questions in this application are complete and true and agree that they will be the basic of the insurance of any coverage by any underwriter or carrier. Subject to the approval of this application, the coverage applied for shall become effective in accordance with the terms of the plan document. I understand that coverage, once offered and declined, may be elected at a later date (1) with respect to health coverage, (a) under the plan document's Special Enrollment Rules or (b) if the plan document provides for Open Enrollment or Late Enrollment (A Late Enrollee is subject to a post-coverage waiting period of eighteen (18) months for pre-existing condition), or (2) with respect to Life Insurance, subject to approval by the carrier upon the submission of a health questionnaire. I understand that I must meet all eligibility requirements before coverage can become effective. I understand that any falsification will result in denial or cancellation of coverage so that the result is no coverage was ever in effect and any claims paid will be reimbursed by me. By my signature below, I acknowledge that all information was entered above prior to my signing this Enrollment Form.

I ACKNOWLEDGE RECEIPT OF THE SUMMARY PLAN DESCRIPTION INCLUDING MY INITIAL COBRA NOTICE OF RIGHTS AND OBLIGATIONS FOR MYSELF AND MY COVERED DEPENDENT(S) (IF ANY)__________ INITIALLED

I HAVE ATTACHED A CERTIFICATE(S) OF CREDITBLE COVERAGE FOR MYSELF AND/OR MY ELIGIBLE DEPENDENT(S) FOR DETERMINATION OF ANY CREDIT TOWARD THE PLANS POST-COVERAGE WAITING PERIOD FOR PRE-EXISTING CONDITIONS.

SIGNATURE OF EMPLOYEE______________________________ DATE SIGNED______________________

SPECIAL ENROLLMENT RULES

FOR INDIVIDUALS LOSING OTHER COVERAGE - IF YOU ARE DECLINING ENROLLMENT FOR YOURSELF OR YOUR DEPENDENTS (INCLUDING YOUR SPOUSE) BECAUSE OF OTHER HEALTH COVERAGE, YOU MAY IN THE FUTURE BE ABLE TO ENROLL YOURSELF OR YOUR DEPENDENTS IN THIS PLAN, PROVIDED YOU REQUEST ENROLLMENT WITHIN 30 DAYS AFTER YOUR OTHER COVERAGE ENDS. EACH OF THE CONTIIONS SET FORTH IN THE SPECIAL ENROLLMENT PERIODS SECTION OF THE SUMMARY PLAN DESCRIPTION MUST BE MET.

FOR NEWLY ACQUIRED DEPENDENTS - IF YOU HAVE A NEW DEPENDENT AS A RESULT OF MARRIAGE, BIRTH, ADOPTION, PLACEMENT FOR ADOPTION OR OBTAINING CUSTODY OF A FOSTER CHILD, YOU MAY BE ABLE TO ENROLL YOURSELF AND YOUR DEPENDENTS, PROVIDED THAT YOU REQUEST ENROLLMENT WITHIN 30 DAYS AFTER THE MARRIAGE, BIRTH, ADOPTION, PLACEMENT FOR ADOPTION OR OBRTAINING CUSTODY OF THE FOSTER CHILD.

I DECLINE ENROLLMENT FOR:

- ☐ MYSELF (I HAVE NO ELIGIBLE DEPENDENTS)
- ☐ MYSELF AND MY ELIGIBLE DEPENDENTS
- ☐ MY ELIGIBLE DEPENDENTS

THE REASON THAT I AM DECLINING ENROLLMENT IS:

- ☐ HAS OTHER COVERAGE UNDER A GROUP HEALTH PLAN OR HAVE HEALTH INSURANCE COVERAGE (AS INDICATED IN THE 'OTHER HEALTH COVERAGE' SECTION.
- ☐ OTHER - (PLEASE EXPLAIN) ______________________________

SIGNATURE OF EMPLOYEE:______________________________ **DATE:** ____________________