Health Insurance Enrollment/Waiver Form

Office Use Only **Event Date** _____

Qualifying Event ☐ Open Enrollment ☐ New Hire ☐ Other **Benefit Effective** _____

Please check one ☐ **Standard** ☐ ***Basic (MUST HAVE AT LEAST 10% OR 60 PLANS)**

PLEASE PRINT CLEARLY

Employee Name _____ **SS#** _____

Date of birth _____ **Phone Number with Area Code** _____

Street Address _____

Apt/Suite/PO Box _____ **Gender** **Female** ☐ **Male** ☐

City _____ **State** _____ **Zip Code** _____ **County** _____

E-mail Address _____ **Date of full-time hire** _____

DEPENDENTS TO BE COVERED

(Employee should notify the insurance company if any dependent's address is different from the employee's address.)

Name	Gender	Relationship	Date of Birth	Social Security #

Will you or any covered family member have any other medical coverage, such as Medicare or a spouse's medical coverage, in effect at the same time as this coverage? If yes, list all:

Medicare ID or Carrier Name _____

Starting Date _____ **Ending Date** _____

Covered Member ☐ Employee ☐ Spouse ☐ Child(ren)

Medicare ID or Carrier Name _____

Starting Date _____ **Ending Date** _____

Covered Member ☐ Employee ☐ Spouse ☐ Child(ren)

continued on next page

WAIVER (refusal of coverage)

I acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through my employer. I proclaim that I was not pressured or forced by my employer, the writing agent, or the insurance company into waiving (declining) coverage. If I have waived any coverage offered to me or my dependents, my signature below is evidence of this action.

I hereby waive coverage for (check all that apply)

Medical for: ☐ Myself ☐ My spouse ☐ My dependent children

I decline to apply for group coverage because of:

☐ Spousal coverage

☐ Medicare supplement

☐ Individual coverage

☐ Coverage under another carrier's plan provided by my employer

☐ Other

True and complete acknowledgement

I understand, agree and represent:

- I have read this document or it has been read to me and answers provided are true and complete to the best of my knowledge and belief.
- Neither my employer nor the agent can waive any question, determine coverage or insurability, alter any contract or waive any of the insurance company's other rights and requirements.
- If this application for coverage is accepted, coverage will be effective on the date specified by the insurance company on the certificate of coverage/certificate of insurance. If I have a new dependent as a result of a qualifying event, I may in the future be able to enroll myself or my dependents provided I request enrollment within 31 days after the qualifying event.
- In the event that I should decide to apply for coverage hereafter, that subsequent application shall be subject to the applicable terms and conditions of the master group contract(s) or plan provisions which may require additional limitations and waiting periods.
- If I am declining coverage for myself or my dependents (including my spouse) because of other coverage, I may in the future be able to enroll myself or my dependents provided that I request enrollment within 31 days after my other coverage ends.
- If any deductions are required for this coverage, I authorize those deductions from my earnings.
- My signature on this form authorizes any doctor, hospital, or other provider of treatment to furnish the insurance company any and all medical records pertaining to any person covered by the plan. I am responsible for any fee for these records.
- Any misrepresentation contained herein relied on by the insurance company may be used to reduce or deny a claim(s) or void the contract within the contestable period if such misrepresentation materially affected the acceptance of the risk.
- It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Authorization

My dependents and I understand and agree:

- The information obtained by use of this authorization may be used by the insurance company to make claims determinations, determine eligibility for coverage, eligibility for benefits under an existing policy and plan administration.
- Any information obtained will not be released by the insurance company to any person or organization except to reinsuring companies, or other persons or organizations performing health care operations or business or legal services in connection with an application, claim or as may be otherwise lawfully required, or as I (we) may further authorize.
- A photographic copy of this authorization shall be as valid as the original.
- * **If I choose the Basic Plan, I understand that if 10% (approximately 60) of the plans do not choose the Basic Plan, I will be enrolled in the Standard Plan automatically.**
- This document, together with any supplements, will form part of any contract and be the basis for any certificate of coverage/certificate of insurance issued.

Employee Signature _____ **Date** _____