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New Enrollment　　Add Dependents
Coverage Change　　Reinstatement
Special Enrollment: ____________________________

Self-Funded Group Enrollment Form

Employer:	Group #	# of hours worked/wk:

Employment Date:	Effective Date:	Employee Class:	Occupation:	Salary:

Employee:	SS #

Network Election:	Male Female	Single Married Widowed Divorced Separated Domestic Partner	Employee Coverages Medical Dental Vision STD　Life　HRA	Dep. Coverages Medical Dental Vision HRA

Date of Birth:	Email address:

Street Address:

City:	State:	Zip Code:

Home Phone: ( ) -	Work Phone: ( ) -
Full Name of Beneficiary:	Relationship:

Please list only those dependents (including spouse) you wish to enroll. For newborns only: if SS number is not yet available, proceed with enrollment and send SS number after received. Otherwise, SS number is required to enroll a dependent.

Dependent Name	Social Security #	Gender	Date of Birth	Relationship

Are **you** or any of your **dependents** covered under another health plan?　Yes　No

If %Yes+, who is covered?　Effective Date of coverage:

Insurance Carrier(s):	Spouse¢s Employer:

Before signing below, please read the important notices on the back of this form.

I certify that the preceding statements and answers are true and complete to the best of my knowledge.

Employee Signature ____　Date _______________________________

TO DECLINE COVERAGE - Complete below only if you (or dependent) DO NOT want to enroll in your employer's health plan.

By completing and signing below, you: 1) understand you are eligible for group health coverage and have had the plan explained; and 2) waive all claims to benefits under the plan.

You decline coverage for:　☐ yourself　☐ yourself & all dependents　☐ dependents　☐ spouse
Reason:　☐ covered by spouse¢s plan　☐ premium cost　☐ covered elsewhere　Domestic Partner

If covered elsewhere, name of insurance company:

If you are declining enrollment for yourself or your dependents (including your spouse), please read the important notice on the back of this form titled "Special Enrollment Rights" to learn about your and your dependents' special enrollment rights under the health plan.

Employee Signature: ____　Date Coverage Waived: ______________________

NOTICE OF SPECIAL ENROLLMENT RIGHTS FOR PLANS SUBJECT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependentsqother coverage). However, you must request enrollment within 30 days (or any longer period that applies under the plan) after your or your dependentsqother coverage ends (or after the employer stops contributing toward the other coverage).

If the plan requires that you state in writing whether coverage is being declined due to other health coverage, then you or your dependents will not be eligible for special enrollment due to loss of coverage if you fail to provide this written statement. If you are declining coverage now for yourself or any of your dependents, be sure to fully complete and sign the %To Decline Coverage+section on the reverse side of this form to protect any special enrollment rights.

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days (or any longer period that applies under the plan) after the marriage, birth, adoption, or placement for adoption.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state childrenqs health insurance program is in effect, you may be eligible to enroll yourself and your dependents in the plan if you or your dependents lose eligibility. However, you must request enrollment within 60 days after your or your dependentsqcoverage ends under Medicaid or a state childrenqs health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state childrenqs health insurance program with respect to coverage under the plan, you may be able to enroll yourself and your dependents in the plan. However, you must request enrollment within 60 days after your or your dependentsqdetermination of eligibility for such assistance.

To request special enrollment or obtain more information, contact your employer.

FRAUD NOTICE

Any person who knowingly and with intent to defraud the plan, files an application for coverage or statement of claim containing any materially false information or conceals information for the purpose of misleading, commits a fraudulent act which is a crime and subjects such person to criminal and civil penalties.