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❒ New Enrollment ❒ Add Dependents
❒ Coverage Change ❒ Reinstatement
❒ Special Enrollment: _____

Self-Funded Group Enrollment Form

Employer:		Group #	# of hours worked/wk:	
Hire Date:	Effective Date:	Life Class:	Occupation:	Salary:
Employee:		SS #		

Date of Birth:	❒ Male ❒ Female	❒ Single ❒ Married ❒ Widowed ❒ Divorced ❒ Separated	Employee Coverages ❒ Medical ❒ Dental ❒ Vision ❒ Rx ❒ STD ❒ Life
Network Election:			Dep. Coverages ❒ Medical ❒ Dental ❒ Vision ❒ Rx

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. Social Security number is not necessary for newborns.

Dependent Name	Social Security #	Sex	Date of Birth	Relationship

If you have listed a dependent child who has reached age 19, indicate if full-time student:

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: ❒ HMO elected ❒ covered by spouse's plan ❒ premium cost ❒ covered elsewhere

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 dependents' other coverage). However, you must request enrollment within 30 days (or any longer period that applies under the plan) after your or your dependents' other 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 children's 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 dependents' coverage ends under Medicaid or a state children's 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 children's 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 dependents' determination of eligibility for such assistance.

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

NOTICE OF OPPORTUNITY TO ENROLL IN CONNECTION WITH EXTENSION OF DEPENDENT COVERAGE TO AGE 26 FOR PLANS SUBJECT TO THE AFFORDABLE CARE ACT

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the plan. Individuals may request enrollment for such children at least 30 days from the date of notice. Enrollment will be effective retroactively to the earlier of: (a) the effective date of coverage stipulated by the employer; or (b) the first day of the first plan year beginning on or after September 23, 2010.

For more information, contact your employer.

NOTICE THAT LIFETIME LIMIT NO LONGER APPLIES AND ENROLLMENT OPPORTUNITY FOR PLANS SUBJECT TO THE AFFORDABLE CARE ACT

Beginning on the earlier of: (a) the date stipulated by the employer; or (b) the first day of the first plan year beginning on or after September 23, 2010, the lifetime limit on the dollar value of benefits under the plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have at least 30 days from the date of notice to request enrollment.

For more information, contact your employer.

PRE-EXISTING CONDITION EXCLUSION FOR PLANS SUBJECT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

Some medical conditions that you or your dependents may have before joining the plan could be excluded from coverage for a period of time. If the plan imposes a pre-existing condition exclusion, you or a dependent might be able to reduce the length of the exclusion period by prior health coverage called "creditable coverage."

To obtain information about whether a pre-existing condition exclusion applies and how it might be offset with creditable coverage, 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.