



Service Center- Fax # (866) 867-2752

Enrollment / Change / Waiver Form

GROUP NAME: \_\_\_\_\_ GROUP ID: \_\_\_\_\_ EFFECTIVE DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

MEDICAL PLAN:  HealthNet<sup>1</sup> PLAN NAME: \_\_\_\_\_

DENTAL PLAN: PLAN NAME: \_\_\_\_\_ VISION PLAN: PLAN NAME: \_\_\_\_\_

New Enrollment  Enrollment Change  Address Change  Name Change

ENROLLMENT/CHANGE REASON:  New Employee  Rehired Employee  Open Enrollment  Transfer from Other Plan  Marriage

Divorce  Death  Birth  Adoption (Legal Documents May Be Required)  Dependent Change  Involuntary Loss of Other Coverage (Prior Coverage Certificate required)

1. GROUP INFORMATION (TO BE COMPLETED BY THE GROUP): Date of Hire \_\_\_\_/\_\_\_\_/\_\_\_\_

Job Title: \_\_\_\_\_ Hours Per Week: \_\_\_\_\_ Work Location: \_\_\_\_\_

2. EMPLOYEE INFORMATION (EMPLOYEE TO COMPLETE SECTIONS 2-10)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Mailing Address (If Different) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Business Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Email \_\_\_\_\_

3. ENROLLMENT INFORMATION *Notes: Please check the Enroll if enrolling, Delete to change, or leave blank. Use a separate sheet to list additional enrollees.*

Medical		Dental		Vision		If waiving coverage, select reason	Relationship to Employee	Name (Last, First, MI)	Social Security Number	Gender M/F	BirthDate MO/Day/YR	Date of Event*
Enroll	Delete	Enroll	Delete	Enroll	Delete							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other Group Cvg <input type="checkbox"/> Individual <input type="checkbox"/> Other _____	SELF					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other Group Cvg <input type="checkbox"/> Individual <input type="checkbox"/> Other _____	<input type="checkbox"/> Spouse <input type="checkbox"/> Reg. DP <input type="checkbox"/> Non-Reg. DP					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other Group Cvg <input type="checkbox"/> Individual <input type="checkbox"/> Other _____						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other Group Cvg <input type="checkbox"/> Individual <input type="checkbox"/> Other _____						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other Group Cvg <input type="checkbox"/> Individual <input type="checkbox"/> Other _____						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other Group Cvg <input type="checkbox"/> Individual <input type="checkbox"/> Other _____						

\*Date of Marriage, Divorce, Adoption, Death, or Loss of Coverage;

Dependent age limit is 26 (without regard to student status). Is any dependent over 25 applying for coverage eligible due to disability?  No  Yes, Name(s): \_\_\_\_\_

# Enrollment / Change / Waiver Form (continued)

**4. CONSUMER DRIVEN HEALTHCARE ADMINISTRATION** (If your employer selected any of the below options, please indicate if you want to enroll. Also complete and attach the BSI enrollment form)

FSA  Yes  No      HRA  Yes  No      DCAP  Yes  No      HSA  Yes  No

**5. MEDICARE FOR EMPLOYEE AND ALL DEPENDENTS**

Is any person applying covered by Medicare?  No, go to section 6  Yes, please complete the following:

Name \_\_\_\_\_ Medicare ID # \_\_\_\_\_ Effective Date: Part A \_\_\_\_/\_\_\_\_/\_\_\_\_ Part B \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason:  Age  Disability  
 End Stage Renal Disease

Name \_\_\_\_\_ Medicare ID # \_\_\_\_\_ Effective Date: Part A \_\_\_\_/\_\_\_\_/\_\_\_\_ Part B \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason:  Age  Disability  
 End Stage Renal Disease

**6. CONTINUED COVERAGE FOR SPOUSE AND DEPENDENTS**

Is your spouse or child applying for continued coverage?  No  Yes, complete and attach either a COBRA Enrollment Form or a Continuation of Coverage Application.

**7. PRIOR COVERAGE FOR ENROLLING EMPLOYEE AND ALL DEPENDENTS**

Have you and/or eligible dependents been covered by other medical insurance in the past six (6) months?

No, go to section 8  Yes, please complete the following section: **Notes:** Some Groups have a waiting period before an employee is eligible for benefits. If you are not sure of your enrollment date, please contact your Group Benefits Administrator. Use a separate sheet to list additional prior carrier coverage.

Prior Plan Name \_\_\_\_\_ Prior Plan Phone Number ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Date Coverage Began \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Subscriber ID Number \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Names of all Person(s) Covered \_\_\_\_\_

Will this coverage be in effect after the coverage with this plan begins?  Yes  No, enter date coverage ended \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**8. OTHER COVERAGE FOR ENROLLING EMPLOYEE AND ALL DEPENDENTS** *Helpful Hint: Failure to complete prior coverage information could affect payment of claims.*

Will any person applying for coverage be covered under another plan after the coverage with this plan begins?  No, go to section 9  Yes, complete the following section:

Other Plan Name \_\_\_\_\_ Other Plan Phone Number ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Date Coverage Began \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Subscriber ID Number \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Names of all Person(s) Covered \_\_\_\_\_

Is this person covered as a retired or laid-off employee or is this person a covered dependent of such an employee?  No, go to section 9  Yes, enter the date retired or laid-off \_\_\_\_/\_\_\_\_/\_\_\_\_

**9. Life and AD&D Insurance: Life & AD&D Insurance is underwritten by LifeWise Assurance Company. For all employees who receive Life & AD&D benefits please complete the following:**

Beneficiary Designation: Subject to the terms of my Group Insurance Policy, I hereby designate or amend and revoke any former beneficiary named by me, and I now designate as Beneficiary:

Name (Last, First, MI,) \_\_\_\_\_ Relationship: \_\_\_\_\_ Beneficiary's Mailing Address \_\_\_\_\_

Name (Last, First, MI,) \_\_\_\_\_ Relationship: \_\_\_\_\_ Beneficiary's Mailing Address \_\_\_\_\_

**10. EMPLOYEE SIGNATURE** In applying for enrollment as indicated on this application, I declare that to the best of my knowledge all of the information on this form is true and complete, and all of the persons for whom I am requesting enrollment are eligible for coverage. The changes on this form supersede all previous forms submitted. I authorize my employer to deduct from my earnings the amount, if any, for the coverage selected. AGC Health Benefit Trust, BSI, and The Insurance Companies may collect, use and disclose protected personal information (PPI) about each individual enrolled under this Application in order to carry out its routine business functions, which, but are not limited to, determining eligibility for benefits, paying claims, coordinating benefits with other insurance carriers or payers, underwriting, and conducting case management, care management and quality reviews. The Insurance Companies may also disclose PPI to state and/or federal agencies, or other third parties, as required by law.

Employee Signature \_\_\_\_\_ Date Signed \_\_\_\_ / \_\_\_\_ / \_\_\_\_