

# Employer Benefit

## Group Enrollment Form

- New Enrollment
- Add Dependents
- Beneficiary Change
- Change of Address

Office # 1-800-456-5615

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P.O. Box 2568

Mansfield, Ohio 44906

**PLEASE PRINT IN DARK INK** (Insured's Signature Required / This form is to be filled out by Insured ONLY!) Attach HIPAA Certificate to Form

**Employer to Fill Out:** Policy # \_\_\_\_\_ Coverage Begin Date: \_\_\_/\_\_\_/\_\_\_

Plan A \_\_\_ Plan B \_\_\_ Plan C \_\_\_ Plan D \_\_\_

Employer Name: \_\_\_\_\_

Employee Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (M.I.) \_\_\_\_\_

Address: \_\_\_\_\_ (City) \_\_\_\_\_ (St) \_\_\_\_\_ (Zip) \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Sex \_\_\_ Soc. Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Coverage Requested: Single \_\_\_ Family \_\_\_

Name of Beneficiary: \_\_\_\_\_ Relationship: \_\_\_\_\_

Date Full-Time Employed: \_\_\_/\_\_\_/\_\_\_ Are you currently: Disabled?(YorN) \_\_\_ Actively @ Work?(YorN) \_\_\_ On Cobra?(YorN) \_\_\_

### Disclaimer:

To the best of my knowledge, I represent that the answers I have given on this enrollment form are full, complete, and true. I understand that misstatements, misrepresentations, or omissions may result in the cancellation of insurance coverage as of the effective date with no benefits due or payable within the plan of coverage for which application was made.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or other organization, institution or person, that has any records or knowledge of me, my health or the health of my dependents to give Employer Benefit Services any such information. A photocopy of this Authorization shall be as valid as the original.

Applicant Signature: \_\_\_\_\_ Date Signed: \_\_\_/\_\_\_/\_\_\_

### Dependent Information:

Name of Spouse _____	Sex _____	BirthDate ___/___/___	Soc.Security# _____ - _____ - _____
Child _____	Sex _____	BirthDate ___/___/___	Soc.Security# _____ - _____ - _____
Child _____	Sex _____	BirthDate ___/___/___	Soc.Security# _____ - _____ - _____
Child _____	Sex _____	BirthDate ___/___/___	Soc.Security# _____ - _____ - _____
Child _____	Sex _____	BirthDate ___/___/___	Soc.Security# _____ - _____ - _____

Note: If child is over the age of 19, please indicate if a full-time student: \_\_\_(Y or N)

Name of Educational Institution: \_\_\_\_\_ Phone#(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

(For additional insureds, please use this same area on another enrollment form and attach to this form)

Are you or any of your dependents now insured for insurance through another Employer?

Yes \_\_\_ Name of other Insurer or Employer \_\_\_\_\_ No \_\_\_

### WAIVER OF COVERAGE

I have been given the opportunity to apply for group insurance through my employer. After due consideration, I have decided not to take advantage of this offer for:

- Myself (and Dependents, if any)
- My Spouse
- My Children
- My Spouse and Children

Reason for Waiver: \_\_\_\_\_

Signed: \_\_\_\_\_ Date Signed: \_\_\_/\_\_\_/\_\_\_

I understand that, if I apply for this insurance at a later date, I will have to furnish, at my own expense, satisfactory evidence of insurability to Employer Benefit Services on each person to be insured before I/they can become insured.