



EMPLOYER SECTION:	Hire Date: <input type="text"/>	Effective Date: <input type="text"/>	Employee Status
	Location Group#: <input type="text"/>	Salary: <input type="text"/>	ACTIVE
			TERMED

PERSONAL DATA

Social Security #: Employee First Name Middle Employee Last Name Gender:

Street Address: City: State: Zip: Birth Date:

Home Phone: Cell Phone: Work Phone (Optional):

Family Status: Single Employee +Spouse Employee+ Children Family Preferred Email Address:

Name of Insured:	Social Security Number	Date of Birth:	Relationship	Gender:	Health/RX	Optical	Dental	COBRA	Medical PPO
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>					
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>					Medical HDHP
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>					
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>					
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>					

Reason for Waiving: Spouse Employer Plan Individual Plan COBRA from Prior Employer Opt Out Plan Health/Rx Dental Optical

Employer Name:

Street Address: City: State: Zip:

Name of other Plan:

Termination Date: Reason for Termination:

AUTHORIZATION /ASSIGNMENT

I hereby apply for benefits under the group benefit plan(s) provided by my employer subject to all of its terms, conditions and provisions. I represent that all information provided above is true and complete to the best of my knowledge. I understand and agree that omissions, misrepresentation or misstatements about myself or my named dependents may result in claim denial or termination of coverage if such information materially affects eligibility for coverage. If a contribution towards the cost is required, I authorize the necessary deductions from my earnings. I further authorize and direct that all benefit payments be made directly to the health care provider rendering a health care service payable under the plan(s).

Signature: _____ **Date:** _____

REFUSAL OF BENEFITS

This is to certify that I have been given the opportunity to examine and apply for the group plan benefits available to me and I have decided not to apply for the group plan benefits for:

	Health/RX	Optical	Dental	COBRA
Myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My Dependents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I understand that future applications may require additional waiting periods or other limitations and that the plan may reject a future applicaiton.

Signature: _____ **Date:** _____