EMPLOYEE APPLICATION FOR HEALTH COVERAGE

APPLICATION MUST BE COMPLETED IN FULL AND TRUTHFULLY

EMPLOYER INFORMATION

Employer Name: ____________________ Address: ____________________

EMPLOYEE INFORMATION

Employee Division: ____________________

Preferred Provider Organization: ____________________

Employee Name: ____________________
Last First Initial

Address ____________________ Apt/Unit _____ City ____________________ St____ Zip ____________
Number/Street

Social Security No: ____________________ Date of Birth: ____________________ Gender: ☐ Male ☐ Female

Full-Time Date of Hire: ____________________ Normal hours worked per week: ________ Occupation: ____________

Phone No: ( ) ____________________ Email: ____________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Hourly ☐ Salary

COVERAGE INFORMATION

Coverage Type	**APPLYING** for coverage for:	**WAIVING** coverage for:
Medical/Rx	☐ Myself/Employee ☐ Spouse ☐ Child(ren)	☐ Myself/Employee ☐ Spouse ☐ Child(ren)
Dental	☐ Myself/Employee ☐ Spouse ☐ Child(ren)	☐ Myself/Employee ☐ Spouse ☐ Child(ren)
Vision	☐ Myself/Employee ☐ Spouse ☐ Child(ren)	☐ Myself/Employee ☐ Spouse ☐ Child(ren)

If you have elected to WAIVE coverage for benefits as shown above, please check one of the following boxes:

☐ I certify that I have other health coverage. ☐ I certify that I do NOT have other health coverage.

DEPENDENT INFORMATION - Must be completed even if WAIVING coverage

	First Name	MI	Last Name	Gender	Date of Birth	Social Security No.
Spouse						
Child 1						
Child 2						
Child 3						
Child 4						

*By including my step-child(ren) and signing this application, I verify that the above child(ren) is (are) primarily dependent upon me for care and financial support and living with me in a parent-child relationship (please include a copy of the step-child's birth certificate for our records).

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OTHER INSURANCE INFORMATION

Do you or any of your dependent(s) have other insurance? ☐ Yes (complete below) ☐ No

First and Last Name	Type(s) of other insurance	Insurance Carrier/ Address/Phone #	Policyholder's Name/ Date of Birth / Employer
	☐ Medical/Rx ☐ Dental ☐ Vision		
	☐ Medical/Rx ☐ Dental ☐ Vision		

EMPLOYEE STATEMENT AND SIGNATURE

I hereby: Request enrollment in the Employer Sponsored Self-Funded Health Plan established and maintained by my Employer (Plan Sponsor) for it's eligible employees and their eligible dependents; Represent that I am an eligible employee of the Employer; Represent that my statements and answers to the questions in this enrollment form are true and complete to the best of my knowledge and belief; and Authorize the Employer to deduct any required Plan contribution from my earnings.

I FURTHER ACKNOWLEDGE AND UNDERSTAND: All Plan benefits are self-funded (self-insured) by the Employer; The Employer (Plan Sponsor) is solely responsible for all benefit payments; Coverage is not effective until the Plan approves this enrollment form; Plan benefits are available only if a person is covered under and all required contributions for such coverage have been received by the Plan; A full description of the medical expense benefits under the Plan appears in the Plan Document; The agent, submitting this enrollment, lacks authority to change the enrollment form, approve Plan coverage, alter Plan terms or adjust claims; the Employer has delegated certain non fiduciary, ministerial administrative acts, duties and responsibilities of the Plan to SecureOne Benefit Administrators, Inc. a licensed third-party administrator; However, the Sponsoring Employer remains the Plan Sponsor, Plan Fiduciary, Plan Administrator and Plan Trustee and is responsible for all coverage determinations and benefit payments. SecureOne Benefit Administrators, Inc. does not insure the Plan and is not responsible for funding benefit payments; My statements and answers in this enrollment form will be the basis for approving Plan coverage and any material misrepresentation or omission may result in an increase in Plan contribution rates or termination of my coverage; Any person who knowingly and with intent to defraud, submits an enrollment form or files a claim containing a materially false statement or omitting materially false information may be found guilty of fraud in a court of law, which if found guilty, may be terminated from the Plan, re-evaluation of rates to the Employer or be reimbursed of all claims paid under the illegal act.

ANNUAL OPEN ENROLLMENT PERIOD: You or your dependents may also enroll health care coverage under your employer sponsored self-funded Plan by submitting a completed enrollment form during an annual open enrollment period. The annual open enrollment period will begin 31 days before the Employer's (Plan Sponsor) renewal date and will be for a period of 31 days. The Employer is responsible for advising all of its Employees of annual open enrollment periods.

SPECIAL ENROLLMENT RIGHTS: If you acquire a new dependent by marriage, birth, adoption or placement for adoption, he/she may be able to enroll without delay or penalty if you request enrollment within 31 days (of the marriage, birth, adoption or placement for adoption); If you decline enrollment for yourself and/or any dependent (including your spouse) because of other health plan or group insurance coverage and that person subsequently becomes ineligible for the other coverage (or the employer stops contributing towards that coverage) he/she may be able to enroll without delay or penalty, if you request enrollment within 31 days of ineligibility or termination of employer contributions; If you decline enrollment for any dependent (including your spouse because of coverage under Medicaid or a State child health plan, and that dependent's coverage is subsequently terminated due to ineligibility, he/she may be able to enroll without delay or penalty, if you request enrollment within 60 days of the termination for coverage; If you decline enrollment for any dependent (including your spouse) and that dependent subsequently becomes eligible for a premium assistance subsidy from Medicaid or a State child health plan, he/she may be able to enroll without delay or penalty, if you request enrollment within 60 days of eligibility for the subsidy. To request special enrollment contact the Employer or SecureOne Benefit Administrators, Inc. at 800-876-7475.

PERSONAL INFORMATION NOTICE: As required by law, this notice is intended to inform you that 1) Personal information may be collected from third parties; 2) Such information as well as other personal or privileged information collected by the health plan or its legal representative may be, in certain instances as prescribed by law, disclosed to other third parties without your prior authorization; 3) You have the right to access and correct the collected information; 4) Your right to access does not include any information which relates to and is collected in connection with, or in reasonable anticipation of a claim or civil or criminal proceeding; 5) We will provide a more detailed notice of information practices upon request.

AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize the disclosure of all nonpublic personal information and individually identifiable protected health information for me (and my dependent(s), if applicable), including but not limited to employment status, other health plan coverage, diagnosis, prognosis, medical treatment or care and physical or mental conditions (including alcohol or drug dependency), by any physician, medical practitioner, hospital, other medical related facility, insurance company, employer or benefit plan having such information, to the health plan or it's legal representative, agent or vendor, for the purpose of processing enrollment and may request a copy of this authorization; that enrollment but not the processing of claims, is condition on my signing this authorization; that this authorization will be used as it's own document, separate from the enrollment form; that a photocopy of this authorization may be re-disclosed and may no longer be covered by federal or state privacy laws and that I have the authority to act as the personal representative of my dependent(s) (if requesting dependent coverage).

PRE-NOTIFICATION: I understand that the self-funded Employer (Plan Sponsor) health plan I am applying for contains pre-notification requirement for any inpatient or outpatients services.

DISCLOSURES: I understand no coverage exists unless and until my Employer (Plan Sponsor) receives notification in writing from SecureOne Benefit Administrators, Inc. office indicating coverage for my dependents and me is active and the effective date of the coverage.

I understand the agent does not have the authority to change or waive any of the provisions of this application, nor any of the provisions, terms or conditions or any other forms or materials supplied by Employer (Plan Sponsor) or SecureOne Benefit Administrators, Inc., nor bind SecureOne Benefit Administrators, Inc. to any promises of coverage.

I am aware that I may be required to contribute toward the cost of the Employer (Plan Sponsor) Self-Funded Health Plan. I ask my employer to deduct my portion of the contribution for this coverage from my pay.

I understand I may be contacted by phone by from SecureOne Benefit Administrators, Inc. during its regular business hours to confirm/obtain information.

I/We have read the enrollment application and have completed the sections that apply to my/our requirements.

Employee Signature____ Date________________

Spouse Signature____ Date________________

(required whether or not spouse is electing coverage)

DO NOT WRITE IN THIS AREA

Group #: ___________________ Effective Date: ___________________ Coverage: ☐ EE ☐ FAM ☐ ES ☐ EC Life Volume: ____________________

Type of Coverage: ☐ Medical/Rx ☐ Vision ☐ Life Notes:____

Term Date: ___________________ Reins. Date: ____________________ COBRA Start: ___________________ COBRA End: ___________________

Rehire Date: ____________________ Term Date (2) : ____________________ Date Completed: ____________________