EMPLOYEE ENROLLMENT FORM

For Completion By Employer:
APPLICATION BEING MADE FOR:
- ☐ NEW EMPLOYEE COVERAGE
- ☐ RETIREE
- ☐ SPECIAL ENROLLEE (Attach Proof)

APPLICATION BEING MADE FOR: MEDICAL
(Mark all boxes that apply)
- EMPLOYEE COVERAGE ☐
- SPOUSE COVERAGE ☐
- CHILD(REN) COVERAGE ☐

MISSOURI RESIDENT ☐
NON-MISSOURI RESIDENT ☐

EMPLOYEE NAME - LAST, FIRST, MIDDLE INITIAL	DATE OF BIRTH	SEX ☐ MALE ☐ FEMALE	SOCIAL SECURITY NO.

HOME ADDRESS	CITY	STATE	ZIP CODE	AREA CODE	PHONE NUMBER
SPOUSE ADDRESS (if different)	CITY	STATE	ZIP CODE	AREA CODE	PHONE NUMBER

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED
Date_____

EMAIL ADDRESS (optional)

NAME OF EMPLOYER
Drury University

OCCUPATION

If you are adding a dependent, you may need to provide additional documentation to prove their eligibility.

PRINT NAMES OF DEPENDENTS APPLYING FOR COVERAGE: (LAST, FIRST)	SOCIAL SECURITY NUMBER	LEGAL RELATIONSHIP: (SPOUSE, CHILD, STEP-CHILD, ETC)	GENDER: (M / F)	INDICATE IF FULL-TIME COLLEGE STUDENT (IF YES, SEE BELOW)*	DATE OF BIRTH MO	DAY	YR

***You will be required to provide proof of full-time student status upon receipt of a claim and on a regular basis in the form of a registrar's letter. Other documentation from the school that indicates full-time status and provides beginning/ending dates of the semester and has the dependent's name listed will be acceptable.**

I hereby authorize any health plan, provider of health care services or their Business Associates who have any records, knowledge, or Protected Health Information of me or any family member for whom coverage is requested, to share the information with Corporate Benefit Services of America, Inc., and its Business Associates who provide services for the health plan described herein, for the purposes of determining eligibility for enrollment or underwriting for me and for my family members for the health plan. A photographic copy of this authorization shall be as valid as the original.

I hereby request the amount(s) and Benefits for which I am or may become eligible and hereby authorize my employer to deduct the required contributions, if any, from my earnings.

I certify that the information I have set forth in this application is true and correct to the best of my knowledge. No information has been knowingly withheld or omitted concerning me or my dependents. I understand that providing false information in this application is a crime and may result in the denial of claims or cancellation of coverage. In addition I may be subject to civil and/or criminal penalties.

X _____ _____

Sign your name, DO NOT PRINT OR TYPE — Date

Providing the above authorization makes it possible to determine your eligibility for enrollment in this health plan. As described in the Notice of Privacy Practices, you may revoke this authorization at any time as provided by applicable law and except to the extent that this authorization has been relied upon.

FOR EMPLOYER USE ONLY

DATE OF FULL TIME EMPLOYMENT _____

EFFECTIVE DATE OF CHANGE / COVERAGE _____

COMMENTS _____

FOR HOME OFFICE USE ONLY

☐ Timely ☐ Late ☐ Special ☐ New

Prior Plan Credits
Wait Start _____
Cert Start _____
Cert End _____

Group Number **10845**
Effective Date _____
Account Rep _____

LF _____ MD _____ DI _____ DN _____ DL _____ OTH _____ VS _____ 24 _____ SAL _____ LTD _____ PPO _____

DEPT ____ LIFE2 _____ CV SUFFIX _____ COMMENTS: _____ RETURN TO REP: _____

Return completed form to your employer for mailing to CBSA.
See reverse side for important disclosures regarding declination of coverage and evidence of good health, if applicable.

05110208-0404

Employee Name	Social Security Number

DECLINATION OF ENROLLMENT

IMPORTANT! If you are waiving your right or your dependents' right to coverage under this plan, you must declare the reason for declination in writing below. Failure to declare your reasons for waiving coverage may limit your opportunity to join the plan later and could result in denial of claims for pre-existing conditions.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, 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, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

I have been given the opportunity to participate in the benefit plan, but after due consideration, I have elected not to participate in each of the categories checked below:

	MEDICAL
EMPLOYEE	☐
SPOUSE	☐
CHILD(REN)	☐

Effective Date of Declination _____

List names of dependent to be declined: _____

REASON FOR REFUSAL OF MEDICAL COVERAGE:

☐ Have coverage under another plan. Name of Other Plan _____

☐ Indicate who is currently covered under other plan(s): ☐ Self ☐ Spouse ☐ Child(ren)

Other. Give Explanation _____

Failure to specify that you are declining coverage because you have other coverage may waive your special enrollment rights as described above.

I understand that by not applying for the coverage above, I will not be entitled to those benefits. I further understand that by applying for coverage at a future date, I may be asked to provide health status information for purposes of group rate setting. Penalties such as deferred effective dates or pre-existing condition limitations may be imposed.

X _____ _____

Sign your name, DO NOT PRINT OR TYPE Date

PORTABILITY CREDITS:

Please review the pre-existing condition limitations in your health care plan summary plan document. If a pre-existing provision applies, each participant has the right to prove prior creditable coverage. You have the right to request a Certificate of Creditable Coverage from your prior plan(s).

The pre-existing exclusion period may be reduced by the number of days you were covered under a qualifying prior health plan, provided there is not a gap of sixty-three (63) days or more.

☐ Certification form(s) are attached.
☐ Certification form(s) will be forwarded when received from prior benefit plans.
☐ I did not have health insurance coverage prior to this plan, nor did my dependents.

It is not the responsibility of CBSA or your employer to obtain a Certificate on your behalf. It is the employee's responsibility to obtain the Certificate and submit a copy to his/her employer..

OTHER COVERAGE INFORMATION

This information you provide about other coverage will help us to coordinate benefits with any other group health plan you may have. Please provide the month, day and year for effective dates of coverage.

1. Will you or your dependents continue to be covered under another health insurance while you are covered under this plan?
   ❑ Yes ❑ No

2. Name of policyholder _____ Date of birth _____

3. If this coverage is through your spouses employer, please list the employers name: _____

   If this is not through an employer, please list the source of other coverage: _____

   Name of medical insurance company _____ Telephone number _____

4. Who will continue to be covered: ❑ Self ❑ Spouse ❑ Children

5. List names of covered persons: _____

6. Effective date of medical policy _____ Type of plan: ❑ Group ❑ Individual ❑ COBRA ❑ Other
   Term date of medical policy _____

MEDICARE INFORMATION

1. Do you or your dependents currently have **Medicare** coverage? ❑ Yes ❑ No
   If yes, please answer the following:

2. If you or your spouse are retired, please supply the retirement date(s) _____

3. Name of person covered by Medicare _____ Medicare claim number _____

4. Is Medicare eligibility due to? ❑ Overage 65 ❑ End-stage renal disease ❑ Total Disability

5. Part A effective date _____ Part B effective date _____

OTHER COVERAGE

1. Is there other coverage for your children due to a court decree? ❑ Yes ❑ No

   If yes, name of parent(s) with legal custody of children: _____

   Address of parent(s) with legal custody: _____

   Is there a court order making the non-custodial parent responsible for the child(ren)'s medical/dental expenses?
   ❑ Yes ❑ No If yes, please supply a copy of the legal documentation for this decision.

   Failure to provide this information will result in denial of claims submitted for you or your family members.