Benefit Administrative Systems, LLC

GROUP ENROLLMENT FORM

☐ NEW ENROLLEE ☐ CHANGE IN CURRENT STATUS ☐ SPECIAL ENROLLMENT: SPECIAL EVENT____________
☐ ANNUAL ENROLLMENT DATE OF SPECIAL EVENT____________

DO YOU HAVE A CERTIFICATE OF COVERAGE (IF BLANK, THE PLAN WILL ASSUME "NO") ☐ YES (IF YES, PLEASE ATTACH) ☐ NO

SHADED AREA TO BE COMPLETED BY EMPLOYER

GROUP #	LOCATION #
113331	0100
DATE OF EMP	COV EFF. DATE

EMPLOYER NAME CITY OF EL DORADO

YOUR NAME (Please Print) ____________________
Last First Middle Initial

ADDRESS ____________________
Street Apt #

ADDRESS ____________________
City State Zip Code

Phone- Home Work e-mail

☐ MALE ☐ FEMALE
GENDER

___ / ___ / ___
Mo. Day Year
DATE OF BIRTH

___ ___ ___ / ___ ___ / ___ ___ ___ ___
SOCIAL SECURITY NUMBER

☐ SINGLE ☐ WIDOWED
☐ MARRIED ☐ DIVORCED

COVERAGE (Check only those that apply)

MEDICAL COVERAGE LEVEL: ☐ SINGLE ☐ FAMILY

DEPENDENT INFORMATION (Complete if you elected family Coverage)

DEPENDENT	M	F	FIRST	MIDDLE INT.	LAST	SSN#	DATE OF BIRTH MONTH DAY YEAR	Is child eligible for coverage through any employer-sponsored plan other than a parent's?
SPOUSE	☐	☐						
CHILD	☐	☐						☐ YES ☐ NO
CHILD	☐	☐						☐ YES ☐ NO
CHILD	☐	☐						☐ YES ☐ NO
CHILD	☐	☐						☐ YES ☐ NO

IF YOUR SPOUSE OR CHILDREN HAVE A LAST NAME DIFFERENT FROM YOURS, PLEASE PROVIDE A MARRIAGE LICENSE AND/OR BIRTH CERTIFICATE.
IF YOUR DEPENDENT CHILD IS 26 OR OLDER, PLEASE PROVIDE DISABILITY VERIFICATION. DATE OF MARRIAGE: _____ / _____ / _____

OTHER INSURANCE

ARE YOU OR ANY OF YOUR DEPENDENTS COVERED BY ANOTHER GROUP MEDICAL PLAN? ☐ YES ☐ NO

IF YES, EFFECTIVE DATE OF COVERAGE _____ / _____ / _____

NAME OF PRIMARY INSURED / POLICY HOLDER ____________ DATE OF BIRTH OF POLICY HOLDER _____ / _____ / _____

NAME OF COVERED DEPENDENT(S) ____________

ID NUMBER____________ NAME OF INSURANCE CARRIER OR TPA____________

ADDRESS ____________ PHONE ____________

NAME OF OTHER EMPLOYER PROVIDING COVERAGE ____________ IS MEDICARE/MEDICAID APPLICABLE? ☐ YES ☐ NO

IS YOUR SPOUSE EMPLOYED? ☐ YES ☐ NO IF YES, IS SPOUSE ELIGIBLE FOR INSURANCE THROUGH EMPLOYER NOW OR IN THE FUTURE? ☐ YES ☐ NO

PROVIDE DETAILS ____________

IS THERE A DIVORCE DECREE OR COURT ORDER REQUIRING YOU TO BE FINANCIALLY RESPONSIBLE FOR MEDICAL COVERAGE FOR DEPENDENT CHILDREN?

☐ YES ☐ NO IF YES, PROVIDE COPY

BENEFIT WAIVER STATEMENT

I THE UNDERSIGNED CERTIFY THAT I HAVE BEEN GIVEN AN OPPORTUNITY TO APPLY FOR THE GROUP BENEFIT PLAN OFFERED BY THE COMPANY AND AFTER CAREFUL CONSIDERATION HAVE DECIDED TO DECLINE TO ENROLL IN THE COVERAGE HEREAFTER INDICATED.

DECLINE ☐ MEDICAL

ARE YOU DECLINING DUE TO COVERAGE IN ANOTHER PLAN? ☐ YES ☐ NO (IF BLANK, THE PLAN WILL ASSUME "NO")
IF YES, IS THIS OTHER COVERAGE COBRA? ☐ YES ☐ NO

☐ OTHER (PLEASE EXPLAIN) ____________

IMPORTANT NOTICE: If you refuse coverage for yourself, you automatically refuse coverage for any dependents. 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 30 days after your other coverage ends. Also, you must indicate the reason for declining enrollment to later be eligible under the special enrollment rules. 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, provide that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. The pre-existing condition limitation is stated in the summary plan description. You and/or your dependents have the right to demonstrate creditable coverage by requesting a certificate of coverage from your prior plan or insurer. If necessary and requested, the plan will assist you in obtaining the certificate. I have received and read a summary of the plan description, and any amendments regarding the impact of HIPAA. I certify that the above information is true and accurate.

SIGNATURE OF EMPLOYEE ____________ DATE SIGNED ____________

DATE AND SIGN ENROLLMENT FORM ELECTIONS

SIGNATURE OF EMPLOYEE ____________ DATE SIGNED ____________

If contributions are required for any of the above coverage, I authorize the Company to deduct from my earnings the applicable contribution(s) for the coverage hereafter listed (if none, please indicate.)