

Applicant Name _____

ATTENTION EMPLOYER REPRESENTATIVE: To ensure accurate processing of application, 1) please review all sections and confirm employee completed the appropriate information. 2) Complete section D. 3) Please provide your signature and today's date.

Signature _____ Date _____

Employer Position _____ Phone Number _____

E. Other Medical Coverage Information / Waiver (This section must be completed)

Have you or your dependents had any other medical coverage in the last 12 months? YES NO Will this coverage be terminated? YES NO

Insurance Company Name (use extra paper if needed)	Coverage Start Date	Coverage Stop Date	If Yes, Date
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Coverage type: Group Policy Individual Policy Medicare/Medicaid Other _____

Is this coverage through your spouse's employer? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please provide employer's name	Name, date of birth and Social Security # of policy holder
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Employee's relationship to policyholder	Names of family members with other continuing medical coverage (Including Medicare)
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Medicare effective date Parts A&B	Reason for Medicare eligibility: <input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled <input type="checkbox"/> Kidney Disease	Medicare Claim #
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WAIVER I decline to enroll for this coverage for myself, my spouse, and my dependent children due to:
 Existence of other health coverage Spousal coverage Other Reason (Explain) _____
Check one of the above boxes, then read and sign.

I understand that if I and/or my dependents, if any, waive coverage and desire to participate in the plan at a later date, coverage may be subject to treatment as a late enrollee and may apply at next open enrollment period. I further understand that if I decline enrollment for myself or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 31 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependent provided that I request enrollment within 31 days after such marriage, birth, adoption, or placement for adoption. I have read and understand the "Important Information" located on the back of this form.

X Employee Signature _____ Date Signed _____
(only sign if you are waiving coverage)

F. Medical Research Studies / Additional Products & Services

- Please do not send me information regarding medical research studies.
- Please do not send me information regarding additional products and/or services.

Signature (Form must be signed)

I confirm that the information I have provided on this form is complete and accurate.
I understand that the health benefit plan that I have selected provides reimbursement for certain medical costs, which are more fully described in the current Certificate of Coverage or Summary Plan Description. I understand there may be instances where treatment decisions made by my physician or me or medical expenses which I have incurred may not be covered by my health benefit plan.
I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law. I understand that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes.
I acknowledge that I have received the "Important Information" statement which is included on the back of this form.

Date _____ Employee Signature _____ Spouse Signature _____
(if possible) and applicable