Enrollment Application

1. Participant Information

Last Name ______ First ______ Initial ______
Social Security Number ______ ☐ Female ☐ Male Date of Hire/Rehire ______
Address ______ City ______ State ____ Zip ______
Phone ______ Date of Birth ______ Email Address ______
Employer ______ Division/Location/Local ______
Occupation ______ Salary ______

2. Insurance Information

Are you or any of your dependents covered by any other medical or dental coverage? ☐ Yes ☐ No
If yes, please put a check next to those who have such coverage: ☐ Yourself ☐ Your Spouse ☐ Children
Name of Carrier ______
Policy # ______ Type of Coverage ______
Is member or dependent Medicare eligible? ☐ Yes ☐ No If yes, effective dates: Part A ______ Part B ______
Medicare Eligible Last Name ______ First ______ Initial ______

3. Insurance Beneficiary

Name ______ Relationship to you ______

4. Dependents

Are you under court order to provide health coverage? ☐ Yes ☐ No
If you answered yes, please attach the Qualified Medical Child Support Order (QMCSO) to this form.
Below, please list all dependents to be covered:

	Last Name	First Name	Middle Initial	Check One F=Female M=Male	Rel. to Employee	Date of Birth	Social Security Number
Spouse				☐ F ☐ M			
Child				☐ F ☐ M			
Child				☐ F ☐ M			
Child				☐ F ☐ M			
Child				☐ F ☐ M			

5. Waiver

☐ I am not electing coverage at this time.

I have completed this application and believe it to be true and accurate to the best of my knowledge. I understand that the failure to disclose true and accurate information may result in the immediate termination of the benefits. I understand that the benefits will not be in effect until I have satisfied the eligibility requirements for coverage under the Plan. I herby authorize any physician, medical practitioner, hospital, clinic, veterans administration facility, other medical related facility, insurance or reinsurance company or consumer reporting agency having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition, including drug or alcohol abuse, and/or treatment of me or my named dependents, to give to the Plan, its legal representative, management care firm, pre-certification or utilization review firm, any and all such information.

Signature ______ **Date** ______

------ *For Plan Manager Use Only* ------

Effective Date ______ Class ______ Division Code ______ Client Code ______

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ABS Automated Benefit Services