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Newark, OH 43058-1099 (800) 423-3151

**WARNING:** Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an Insurer or health benefit plan, submits an application or files a claim containing false or deceptive statements is guilty of insurance or health care fraud under state and/or federal law.

**Coverages Elected**  
 Employee Medical  Dependent Dental   
 Employee Dental  Dependent Vision   
 Employee Vision  Dependent Life   
 Employee Life  Other: \_\_\_\_\_  
 Dependent Medical

## EMPLOYEE APPLICATION

**For Office Use Only** Group Account No. \_\_\_\_\_ Employee Effective \_\_\_\_\_ Exclusions: \_\_\_\_\_  
 Life/AD&D \_\_\_\_\_ Option \_\_\_\_\_ Area: \_\_\_\_\_

**PLEASE READ CAREFULLY AND COMPLETE IN INK TO PREVENT YOUR COVERAGE FROM BEING DELAYED.**

**1** Employee Information (Please Print in Ink): Social Security Number \_\_\_\_\_  
 Name \_\_\_\_\_  
Last First Middle Initial  
 Home Address \_\_\_\_\_ Telephone ( ) \_\_\_\_\_  
Street City State Zip

<b>Employee Date of Birth</b> ____/____/____ <small>Mo. Day Yr.</small>	<b>Sex</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Marital Status</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Common Law <small>Complete Supplemental Information - Common Law Relationship</small>	<b>Date Hired</b> ____/____/____ <small>Mo. Day Yr.</small>
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<b>Who Is to Be Covered**</b> <i>If you do not wish to cover your eligible dependents, please complete the waiver area in Section 4.</i> <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee and Spouse <input type="checkbox"/> Employee and Children <input type="checkbox"/> Employee, Spouse and Children	<b>COBRA Election</b> ____/____/____ <small>Mo. Day Yr.</small>	<b>Earnings</b> \$ _____ <input type="checkbox"/> Yearly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly
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Employed by \_\_\_\_\_ Company Name \_\_\_\_\_ City, State of Employment \_\_\_\_\_ Group/Account Number \_\_\_\_\_  
 Occupation \_\_\_\_\_ Hours Worked Weekly \_\_\_\_\_  
 Beneficiary Name \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ Relationship \_\_\_\_\_

**2** **IF APPLYING FOR DEPENDENT COVERAGE LIST BELOW**  
*If you do not wish to cover your eligible dependents, please complete the waiver area in Section 4.*

Full Name	Date of Birth	Sex		S.S. Number (Spouse Only)					
		Male	Female						
<b>Spouse</b>									
<b>Other Dependent(s)</b>				Natural Child	Adopted Child*	Step-Child	Legal Guardian*	You &/or your Spouse provide over 50% of Support?	Full-Time Student? (Y/N)**

\*Please attach to this application copies of the court orders or legal documents creating this relationship. For adopted children, only necessary for initial enrollment after adoption or placement. \*\*If dependent is 19 or older, list the name of the dependent, the educational institution such child is currently attending and the number of credit hours: \_\_\_\_\_

Spouse employed  Yes  No Employed By \_\_\_\_\_ Date of Marriage \_\_\_\_\_

Are you, your spouse or children covered or insured under any other medical, dental or vision coverage (including Medicare and other government plans)?  Yes  No If yes, indicate who is covered under this other coverage, and who the carrier is: \_\_\_\_\_

Are any of the other Dependents listed above in the legal custody of another Person?  Yes  No If yes (complete details):

Dependent	Person with Legal Custody	Relationship to Dependent	Address of Custodian

**Please be sure to sign the back of this form to prevent a delay in processing your request**

3

**NOTICE REGARDING PRIOR HEALTH COVERAGE**

If any person for whom application for coverage has been made above was covered under other health coverage within 62 days (not including any waiting period under this plan or any other plan) of the date such person's coverage would become effective under this plan, he or she may be entitled to credit towards any pre-existing conditions restriction under this plan for any coverage time under one or more prior plans. In order to claim this credit, a certificate of creditable coverage from the prior plan(s), or other evidence documenting the person's prior coverage, should be attached to this form.

If coverage was lost under the prior health plan within 30 days of the date of this application, list reason the coverage was terminated under the prior plan. \_\_\_\_\_

4

**WAIVER OF COVERAGE**

If you are declining enrollment for yourself or your dependents (including your spouse) because you have 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 the time period required by your plan (30 or 31 days - see plan document) 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/or your dependents, provided that you request enrollment within the time limit allowed by your plan after the date of the marriage, birth, adoption, or placement for adoption. Your plan may also allow additional enrollment periods as specified in the plan document. This plan will also allow enrollments as necessary to comply with the terms of medical child support orders, or qualified medical child support orders, as defined in applicable state or federal law. Other than as described, if you fail to enroll at this time you may not be eligible to enroll thereafter, or may be subject to certain restrictions which are described in your plan.

I waive coverage for:  All Medical & Dental  Dependent Medical & Dental

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

Are you waiving the coverage listed above because you and/or your dependents have other health coverage?

Yes  No With whom? \_\_\_\_\_

5

**Read this Statement and Authorization Carefully**

I hereby request coverage and/or insurance and authorize that any requested contribution for the coverage and/or insurance to which I may be entitled be deducted from my earnings. I am employed by the employer shown and am working at least the number of hours per week required by my Employer and shown on the Employer Application. I further understand that any failure to comply with the Utilization Review or Second Surgical Opinion procedures may result in a reduction of benefits. I authorize (1) any physician, hospital, or other health practitioner or facility, (2) any insurance company or health care plan, (3) any state or federal agency providing health care benefits; and (4) any employer to provide the Medical Benefits Companies or their legal representative any information in their possession which is relevant to this application for insurance regarding myself or my listed Dependent(s). This information will be used to determine the eligibility for coverage and/or benefits for myself and my listed Dependent(s) and will be utilized by employees and agents of Medical Benefits Companies with responsibility for (1) reviewing applications and determining eligibility for coverage and/or insurance, and (2) payment of claims. I hereby authorize any provider of health care services, claim administrators, insurers, reinsurers, stop loss carriers and others who have a legitimate need for such information for the purpose of review, investigation, or evaluation of a claim, to supply each other with information about the health status of, and health care services provided to, me and my listed dependents. This authorization is effective on the date signed and shall remain in effect for 30 months from that date. (You or any individual authorized by law to act on your behalf have a right to receive a copy of this authorization). A photographic copy of this authorization shall be as valid as the original. I hereby certify that I have personally answered all of the questions on this form and that my answers are true and complete to the best of my knowledge and belief. I have legal proof which I can furnish upon request of my relationship to any person listed as a Dependent(s) above. I understand any misstatements or failure to report may be used as a basis for rescission or cancellation of the coverage and/or insurance for me and my Dependent(s), if any.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

**I understand that if, upon receipt, the signature is more than 60 days old, a new application will be requested.**