



Group Enrollment Application

for
25 - 49 Employee Medical Lives

ABAS AMERICAN BENEFIT ADMINISTRATIVE SERVICES, INC.
 1733 Park Street, Suite 300
 Naperville, IL 60563
 (800) 736-7872

(Please print in blue or black ink)

Employer Name _____ **Effective Date:** ___/___/___ **Group #:** _____

Check Reason(s) for Application:

New Enrollment

COBRA Continuation (effective date: ___/___/___)

Change to Existing Coverage:

Add Spouse (date of marriage: _____)

Spouse Gaining/Losing Employment (date: _____)

Add Child(ren) (list below)

Terminate Spouse / Child(ren)
(reason: _____ date: _____)

Name Change: From: _____
To: _____

Address Change (list new address as indicated below)

Beneficiary Change (list new beneficiary below)

Health Benefit Election

Coverage Selection:

Employee Only Employee & Child(ren)

Employee & Spouse Employee & Family

Plan Selection:

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PREMIER 90/70	PREMIER 80/60	ADVANTAGE	BASIC MED I	BASIC MED II
<small>Deductible options:</small>	<small>Deductible options:</small>	<small>Deductible options:</small>	<small>Deductible options:</small>	<small>Deductible options:</small>
___ \$ 250	___ \$ 250	___ \$ 500	___ \$1,000	___ \$5,000
___ \$ 500	___ \$ 500	___ \$1,000	___ \$2,500	___ \$5,000
___ \$1,000	___ \$1,000	___ \$2,500	___ \$5,000	
___ \$2,500	___ \$2,500	___ \$5,000		
___ \$5,000	___ \$5,000			

Employee Information:

Last Name		First Name		Middle Initial	Social Security #		
Street Address				City		State	Zip Code
Home Phone #	Date of Birth	Gender	Height	Weight	Hire Date	Hours Worked	Job Title
Marital Status							
<input type="checkbox"/> Single <input type="checkbox"/> Married (date: _____) <input type="checkbox"/> Divorced (date: _____) <input type="checkbox"/> Separated (date: _____) <input type="checkbox"/> Widowed (date: _____)							

If Applying for Dependent Coverage, Complete Section Below:
 (Common Law spouses are NOT eligible for coverage, unless required by law. You must provide proof of college student status from Registrar.)

	First Name & Middle Initial	Last Name <small>(if different from applicant)</small>	Step-Child	Gender	Date of Birth	Height	Weight	Full-Time Student	Social Security #
Sp			Yes <input type="checkbox"/>	<input type="checkbox"/> M <input type="checkbox"/> F	/ /				
Ch			Yes <input type="checkbox"/>	<input type="checkbox"/> M <input type="checkbox"/> F	/ /				
Ch			Yes <input type="checkbox"/>	<input type="checkbox"/> M <input type="checkbox"/> F	/ /				
Ch			Yes <input type="checkbox"/>	<input type="checkbox"/> M <input type="checkbox"/> F	/ /				
Ch			Yes <input type="checkbox"/>	<input type="checkbox"/> M <input type="checkbox"/> F	/ /				

Prior Medical Coverage Information: *Important: You may be eligible for a pre-existing condition limitation credit. Failure to provide the following information may result in a reduction or delay in payment of benefits.*

1. Have you and all dependents you are enrolling been covered by this employer's major medical plan(s) for the past 12 months? Yes No
 If less than 12 months, what date was coverage effective? _____

2. Have you or your dependents been covered under any major medical plan(s) at any time in the past 12 months? Yes No

a. If yes, who was covered? Employee Spouse Children b. Name of Carrier: _____

c. Phone number: (_____) _____ d. Policy/ID #: _____ e. Effective date: _____

f. Termination date: _____ Reason: _____

Life Insurance Amount: (if applicable) Employee \$ _____

Primary Beneficiary: Name _____ Relationship _____

Contingent Beneficiary: Name _____ Relationship _____

(If no beneficiary is designated, benefits will be paid according to the terms of the Certificate of Group Insurance.)

1. Yes <input type="checkbox"/> No <input type="checkbox"/>	Is any applicant currently under a doctor's care, receiving treatment, taking medication or being advised of a condition that will require medical/surgical care or treatment in the future?
2. Yes <input type="checkbox"/> No <input type="checkbox"/>	During the past FIVE years, have you or any of your dependents been examined or treated by a doctor or been hospitalized or operated on for any condition not listed below?
3. Yes <input type="checkbox"/> No <input type="checkbox"/>	Is any person to be covered currently pregnant? If "Yes", what is the due date? ____/____/____

Within the past TEN years, have you or any of your listed dependents had symptoms, conditions, received medical advice, been diagnosed or treated by a physician for any of the conditions listed below? (Answer all conditions with "Yes" or "No")

CONDITIONS	YES	NO	CONDITIONS	YES	NO	CONDITIONS	YES	NO
AIDS/ARC/HIV			Crohn's Disease			Kidney/Urinary Disorder		
Alcohol or Drug Dependency			Depression/Anxiety			Liver Disorder		
Allergies			Diabetes			Lung Disorder		
Alzheimer's Disease			Diverticulitis			Mental/Nervous/Psych. Disorder		
Anorexia/Bulimia			Down's Syndrome			Multiple Sclerosis		
Arthritis			Emphysema			Neurological Disorder		
Asthma			Epilepsy			Paralysis		
Back/Spinal Disorders			Gastric/Peptic Ulcer			Parkinson's Disease		
Blood Pressure/Hypertension			Heart Attack			Skin Disorder/Acne		
Bowel/Stomach Disorder			Heart Blockage			Spina Bifida		
Cancer/Leukemia/Melanoma			Heart Bypass Surgery			Stroke		
Cerebral Palsy			Heart Disorder			Transplants		
Chronic Bronchitis			Hemophilia			Tuberculosis		
Congenital Disease/Defect			Hepatitis			Tumors/Growths/Cysts		
Congestive Heart Failure			Hernia			Ulcerative Colitis		
Coronary Artery Disease			High Risk Pregnancy			Venereal Disease		

Provide details to all "Yes" answers. (Complete and attach applicable medical questionnaires)

PERSON	MEDICAL CONDITION OR DIAGNOSIS	TREATMENT / MEDICATION / DEGREE OF RECOVERY	DATES	NAME, ADDRESS & PHONE # OF DOCTORS, HOSPITALS, ETC.

Complete if you are WAIVING MEDICAL Benefits for you and/or your dependents

I waive medical benefits for: Employee Spouse Child(ren) Employee and Family
Reason for waiving benefits: Spouse's employer plan Medicare/Medicaid Military COBRA Individual Other: _____

If I have waived benefits for myself and/or my dependents (including my spouse) because of other health benefits, I may in the future be able to enroll myself and/or my dependents in this plan, provided that I request enrollment within 31 days after my other benefits end because of involuntary loss of benefits (divorce, death, legal separation, termination of employment, reduction in number of hours of employment). In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 31 days after the date of the event. I further understand that, other than these qualifying events, if this form is submitted after the enrollment period, I cannot enroll until the next annual enrollment period.

Applicant Signature _____ **Date** ____ / ____ / 20____

Employee Statement / Authorization to Release Medical Information

I hereby apply for participation in my employer's Employee Health & Welfare Benefit Plan for myself and/or my dependents listed above and agree to abide by the terms, provisions and limitations as outlined by the Plan Sponsor in the issuance of the Summary Plan Description. I declare all statements contained in this entire form are true and correct and that no material information has been withheld or omitted. I understand that any misstatements or failure to report information which is material to my qualification and participation may be used as a basis for rescission of my participation and/or denial of payment of claim. I agree that no benefits will be effective until the date specified by American Benefit Administrative Services, Inc. (ABAS).

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, the Veterans Administration, the Medical Information Bureau, Inc. (MIB), or any other organization, institution, insurance or reinsurance company, to disclose and release any information in its possession about the medical history, mental or physical condition or treatments of myself and/or my dependents to ABAS or its designee. This authorization includes information about drug abuse, alcoholism or mental illness. I agree a photographic copy of this authorization shall be as valid as the original and that said authorization shall be valid for the maximum length of time permitted by law. I understand that I have the right to receive a copy of this authorization upon request. I authorize my employer to deduct from earnings the contributions (if any) required toward the benefits.

I understand that the plan is an employee health & welfare benefit plan created under the Employee Retirement Income Security Act (ERISA) of 1974 and subject to the rules and regulations adopted by the United States Department of Labor and is not insurance subject to the laws of the state in which I work or reside. This application will be part of the contract. Benefits are effective only after approval by ABAS or its designee and satisfaction of any probationary period.

Applicant Signature _____ **Date** ____ / ____ / 20____