# Group Enrollment Application
***for***
***50+ Employee Medical Lives***

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 & Spouse
- ☐ Employee & Child(ren)
- ☐ Employee & Family

**Plan Selection:**

| ☐ PREMIER 90/70 | ☐ PREMIER 80/60 | ☐ ADVANTAGE | ☐ BASIC MED I | ☐ BASIC MED II |
|---|---|---|---|---|
| *Deductible options:* | *Deductible options:* | *Deductible options:* | *Deductible options:* | |
| ___ $ 250 | ___ $ 250 | | | |
| ___ $ 500 | ___ $ 500 | ___ $ 500 | | |
| ___ $1,000 | ___ $1,000 | ___ $1,000 | ___ $1,000 | |
| ___ $2,500 | ___ $2,500 | ___ $2,500 | ___ $2,500 | |
| ___ $5,000 | ___ $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
☐ Single ☐ Married (*date:*__________) ☐ Divorced (*date:*__________) ☐ Separated (*date:*__________) ☐ 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 *(if different from applicant)* | Step-Child | Gender | Date of Birth | Height | Weight | Full-Time Student | Social Security # |
|---|---|---|---|---|---|---|---|---|---|
| Sp | | | Yes ☐ | ☐ M ☐ F | / / | | | | |
| Ch | | | Yes ☐ | ☐ M ☐ F | / / | | | | |
| Ch | | | Yes ☐ | ☐ M ☐ F | / / | | | | |
| Ch | | | Yes ☐ | ☐ M ☐ F | / / | | | | |
| Ch | | | Yes ☐ | ☐ M ☐ 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.)*

**Medical Information:**
***For Employer groups with 50 or more employee medical lives, please answer the health questions below. If you answer "Yes" to any of the questions, please provide complete details in the space provided below. If necessary, attach a separate sheet to provide additional details.***

1. Yes ☐ No ☐ Have you or any dependent, within the past two (2) years – other than routine physician visits or normal routine child care – *a)* received treatment, or *b)* taken prescription medication, or *c)* been advised of a condition that may require surgery or hospitalization in the future?

2. Yes ☐ No ☐ Are you or any dependent currently pregnant or disabled?

3. Yes ☐ No ☐ Have you or any dependent received treatment or been diagnosed by a physician for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?

4. Yes ☐ No ☐ Have you or any dependents, within the past five (5) years, been diagnosed or treated for ***(circle all that apply)***: Alcohol or Substance Dependency, Burns, Major Bodily Trauma, Hemophilia/Blood Disorder, Neurological Disorder, Heart/Circulatory Condition, Cancer/Tumor, Stroke, Diabetes, Hypertension/High Blood Pressure, Mental/Nervous Disorder, Kidney/Liver/Pancreas Disorder, Emphysema, Ulcerative Colitis, Crohn's Disease, Lupus, Lung Disorder or Rheumatoid Arthritis?

***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. |
|---|---|---|---|---|
| | | | | |
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| | | | | |

## 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______**