Employer Ascot Enterprises

Group # 1251

GROUP BENEFIT PLAN
Enrollment / Change Form

Employee Plans, LLC
P.O. Box 2362, Fort Wayne, IN 46801
(260) 625-7470
www.employeeplansllc.com

EMPLOYEE'S NAME (First Name) (MI) (Last Name)	SS# OR ID#
ADDRESS (Street) (City) (State) (Zip)	PHONE NUMBER
EMAIL ADDRESS	

BIRTHDATE (M/D/Y) | SEX ☐ Male ☐ Female | Do any dependents permanently reside at a different address? ☐ No ☐

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Names: ___

Address: ___

Will the Member be enrolled in any other health plan? ☐ Yes ☐ No Name of Insurance Carrier:

PLEASE LIST ALL ELIGIBLE DEPENDENTS TO BE ENROLLED OR THOSE AFFECTED BY A CHANGE – Documentation may be required

Spouse First Name	MI	Last (if different)	Relationship	Birth Date (M/D/Y)	Social Security Number	☐ M ☐ F	If 26 or Older ☐ Disabled

Is your spouse eligible for insurance through their employer? ☐ Yes ☐ No
If yes, Name of Insurance Carrier: Eff. Date:

Will your spouse be enrolled in any other health plan? ☐ Yes ☐ No
If yes, Name of Insurance Carrier: Eff. Date:

Dependent First Name	MI	Last (if different)	Relationship	Birth Date (M/D/Y)	Social Security Number	☐ M ☐ F	If 26 or Older ☐ Disabled

Will this dependent be enrolled in any other health plan? ☐ Yes ☐ No | If yes, is coverage thru dependent's employer? ☐ Yes ☐ No
Name of Insurance Carrier: | Effective Date | Policy #

Dependent First Name	MI	Last (if different)	Relationship	Birth Date (M/D/Y)	Social Security Number	☐ M ☐ F	If 26 or Older ☐ Disabled

Will this dependent be enrolled in any other health plan? ☐ Yes ☐ No | If yes, is coverage thru dependent's employer? ☐ Yes ☐ No
Name of Insurance Carrier: | Effective Date | Policy #

Dependent First Name	MI	Last (if different)	Relationship	Birth Date (M/D/Y)	Social Security Number	☐ M ☐ F	If 26 or Older ☐ Disabled

Will this dependent be enrolled in any other health plan? ☐ Yes ☐ No | If yes, is coverage thru dependent's employer? ☐ Yes ☐ No
Name of Insurance Carrier: | Effective Date | Policy #

Dependent First Name	MI	Last (if different)	Relationship	Birth Date (M/D/Y)	Social Security Number	☐ M ☐ F	If 26 or Older ☐ Disabled

Will this dependent be enrolled in any other health plan? ☐ Yes ☐ No | If yes, is coverage thru dependent's employer? ☐ Yes ☐ No
Name of Insurance Carrier: | Effective Date | Policy #

Only mark those coverages administered by Employee Plans

Coverages Elected: Single: ☐ Medical ☐ Dental ☐ Vision Family: ☐ Medical ☐ Dental ☐ Vision

SIGNATURE SECTION

Authorization: I hereby authorize any health plan, provider of healthcare services or their Business Associates who have any records, knowledge, or Protected Health Information of me or any family member for whom coverage is requested, to share the information with Employee Plans, LLC and its Business Associates who provide services for the health plan described herein, for the purposes of determining eligibility for enrollment or underwriting for me and for my family members for the health plan. A photographic copy of this authorization shall be as valid as the original.

I hereby request the benefits for which I am or may become eligible and hereby authorize my employer to deduct the required contributions, if any, from my earnings.

I certify that the information I have set forth in this application is true and correct to the best of my knowledge. No information has been knowingly withheld or omitted concerning me or my dependents. I understand that providing false information in this application is a crime and may result in the denial of claims or cancellation of coverage. In addition, I may be subject to civil and/or criminal penalties.

Employee Signature | Date

I have been given the opportunity to participate in the benefit plan, but after due consideration, I have elected **not** to participate in each of the categories checked below:

	MEDICAL	LIFE	DENTAL	VISION	DISABILITY
EMPLOYEE	☐	☐	☐	☐	☐
SPOUSE	☐	☐	☐	☐	
CHILDREN	☐	☐	☐	☐	

Effective date of declination / /

List names of dependent to be declined ___
Reason for declining medical coverage
☐ Have coverage under another plan. Name of other plan ___
☐ Other. Explanation ___

NOTE: If you are declining enrollment for yourself or your dependents (including your spouse) because of 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 30 days 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 also be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Employee Signature | Date

PERSONNEL TO COMPLETE

☐ INITIAL ENROLLMENT ☐ OPEN ENROLLMENT	☐ CHANGE	LIST ABOVE THOSE DEPENDENTS TO BE ADDED OR CANCELED		☐ CANCEL COVERAGE
Division _____Dept. (if used)_____ Hire Date ___ Plan ___ PPO ___ ☐ Special / Late ☐ Salary ___ Effective Date: ___	☐ Change division to ___ ☐ Change name/address (stated above) ☐ Other change ___ ___ Effective Date: ___	☐ ADD DEPENDENT ☐ Marriage ☐ Birth ☐ Adoption ☐ Legal guardianship ☐ Late enrollee ☐ Other ___ Effective Date: ___	☐ CANCEL DEPENDENT ☐ Divorce or legal separation ☐ Death ☐ Age limit ☐ Dependent is no longer disabled ☐ Exhaustion of benefits following employee's disability ☐ Marriage ☐ Other ___ Effective Date: ___	☐ Exhaust of benefits following disability ☐ Terminate employment ☐ Voluntary withdrawal ☐ Leave of absence ☐ Reduction of hours or layoff ☐ Death of employee ☐ Other ___ Date coverage ends ___

Misc:

Personnel's Signature: ___ Date: ___