

Employer Ascot Enterprises

GROUP BENEFIT PLAN Enrollment / Change Form

Employee Plans, LLC
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(260) 625-7470
www.employeeplansllc.com

Group # 1251

EMPLOYEE'S NAME (First Name) (MI) (Last Name)		SS# OR ID#
ADDRESS (Street) (City) (State) (Zip)		TELEPHONE NUMBER
BIRTHDATE (M/D/Y)	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	If you had prior insurance coverage, you may be eligible for coverage of "pre-existing conditions" that would otherwise have been denied by this plan. Will you be providing certificates of prior coverage for yourself and dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Do any dependents permanently reside at a different address? <input type="checkbox"/> No <input type="checkbox"/> Yes Names: _____ Address: _____
Will the Member be enrolled in any other health plan? <input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> M <input type="checkbox"/> F	If 26 or Older <input type="checkbox"/> Disabled
Is your spouse eligible for insurance through their employer? <input type="checkbox"/> Yes <input type="checkbox"/> No				Will your spouse be enrolled in any other health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, Name of Insurance Carrier: _____ Eff. Date: _____				If yes, Name of Insurance Carrier: _____ Eff. Date: _____			
Dependent First Name	MI	Last (if different)	Relationship	Birth Date (M/D/Y)	Social Security Number	<input type="checkbox"/> M <input type="checkbox"/> F	If 26 or Older <input type="checkbox"/> Disabled
Will this dependent be enrolled in any other health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No				If yes, is coverage thru dependent's employer? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name of Insurance Carrier: _____				Effective Date _____ Policy # _____			

Only mark those coverages administered by Employee Plans Hourly Employee Salary Employee

Coverages Elected: Single: Medical Family: Medical

PPO: (Choose One) Sagamore PHCS

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:

EMPLOYEE MEDICAL Effective date of declination / /

SPOUSE

CHILDREN

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 _____

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

SIGNATURE SECTION

PERSONNEL TO COMPLETE