

- New Applicant
 Coverage Change
 Waiver (See Section 5)
 COBRA/MSE Applicant
 Information Update



GROUP BENEFIT SERVICES, INC.
 6 North Park Drive, Suite 310
 Hunt Valley, MD 21030
 (410) 832-1300 (410) 832-1315

Every Item
 Must Be Completed

EMPLOYEE ELECTION FORM

(This is not an application for insurance)

| 1. EMPLOYEE INFORMATION (Your employer will complete the shaded boxes in this section) | | | | | Employer Section | | |
|--|---------------|------------------|---------------------------------|--|---|--------------------------|--|
| Last Name | First Name | M.I. | Social Security Number | | Effective Date(s): Medical: _____ Dental: _____ Vision: _____ Life/STD: _____ LTD: _____ | | |
| Street Address | | | Date of Hire | | | | |
| City | State | Zip Code | Hours Worked Per Week | | GBS Account Number | | |
| Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of Birth | Home Phone # | Business Phone # Extension | | | | |
| Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed | | Date of Marriage | Name of Employer | | | Annual Salary | |
| | | | | | | | |
| | | | | | | Benefit Class/Occupation | |
| | | | | | | | |

| 2. GENERAL INFORMATION (Complete entire line for all listed) | | | | | | | | | | POS or HMO only: | | Existing Patient (Y/N) |
|--|------------|------|-------------------|------------|-----------|-------------------|----------------|---------------------------------------|--|------------------------------|-------------|------------------------|
| Last Name | First Name | M.I. | Social Security # | Birth Date | Sex (M/F) | F/T Student (Y/N) | Disabled (Y/N) | Line 1: PCP Info; Line 2: OB/GYN Info | | Physician Name | Physician # | |
| Self | | | | | | | | | | | | |
| Spouse | | | | | | | | | | | | |
| Child | | | | | | | | | | | | |
| Child | | | | | | | | | | | | |
| Child | | | | | | | | | | | | |
| Participating Dentist or Facility: | | | | | | | | | | Dental Office Provider Code: | | |

3. OTHER HEALTH/DENTAL INSURANCE INFORMATION (You must complete this section or claims may be denied)

Do you or your dependents described on this form have "health" or "dental" coverage with another insurer? Yes No Effective Date: _____ Term. Date: _____

Who is covered? Self Spouse All Other Carrier Name: _____ Policy # _____

Will you or your dependents continue coverage with other insurer? Yes No Other coverage is through Individual Policy Spouse's Employer

Are you covered by Medicare: No Yes Effective Date (Part A) ____/____/____ (Part B) ____/____/____ Medicare # _____

Are any of your dependents covered by Medicare: No Yes Effective Date (Part A) ____/____/____ (Part B) ____/____/____ Medicare # _____

| 4. BENEFIT ELECTION (Indicate level of coverage elected for each benefit offered by your employer) | | | | | |
|---|---|---|--|---|---|
| MEDICAL PLAN | DENTAL PLAN | VISION PLAN | LIFE INSURANCE | SHORT TERM DISABILITY | LONG TERM DISABILITY |
| Carrier: _____ Plan: _____ Group# _____ <input type="checkbox"/> Employee <input type="checkbox"/> Employee & 1 Child <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Family <input type="checkbox"/> Over 65 & Full-Time <input type="checkbox"/> Over 65 & Retired <input type="checkbox"/> NONE | Carrier: _____ Plan: _____ Group# _____ <input type="checkbox"/> Employee <input type="checkbox"/> Employee & 1 Child <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Family <input type="checkbox"/> NONE | Carrier: _____ Plan: _____ Group# _____ <input type="checkbox"/> Employee <input type="checkbox"/> Employee & 1 Child <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Family <input type="checkbox"/> NONE | Carrier: _____ Plan: _____ Group# _____ <input type="checkbox"/> Life Insurance/AD&D <input type="checkbox"/> Supplemental Life Benefit: _____ <input type="checkbox"/> Dependent Life <input type="checkbox"/> NONE | Carrier: _____ Plan: _____ Group# _____ <input type="checkbox"/> Short Term Disability <input type="checkbox"/> Voluntary STD Benefit: _____ <input type="checkbox"/> NONE | Carrier: _____ Plan: _____ Group# _____ <input type="checkbox"/> Long Term Disability <input type="checkbox"/> Voluntary LTD <input type="checkbox"/> NONE |

LIFE INSURANCE BENEFICIARY: _____ RELATIONSHIP: _____

5. WAIVER

I hereby certify that the benefits provided by my Employer have been explained to me, that I have been given an opportunity to elect coverage and that I voluntarily decline to participate in the benefits checked "NONE" at this time. I understand that I may be required to wait until the next open enrollment period (if applicable) or until a Special Enrollment event for medical or dental coverage, or be required to provide evidence of insurability for life or disability benefits.

EMPLOYEE SIGNATURE (Waiver Only): _____ Date: _____

Reason for Waiver: Coverage Elsewhere Carrier Name: _____ Not Interested

CERTIFICATION: The foregoing statements and answers are true and complete to the best of my knowledge, information and belief. I certify that I am the spouse, parent, legal guardian (or the dependent has been placed in my home for adoption) of the dependents listed above and they are dependent upon me for primary support by the IRS.

EMPLOYEE SIGNATURE: _____ DATE: _____

EMPLOYER SIGNATURE/VERIFICATION: _____ DATE: _____