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EMPLOYEE ELECTION FORM

☐ New ☐ Member adding line of coverage ☐ Medical WAIVER\*- (Complete section 1, 5 & 6 Only) ☐ COBRA

1 Employer Name \_\_\_\_\_ Employer Phone (\_\_\_\_) \_\_\_\_\_
Employee Name \_\_\_\_\_ Social Security # \_\_\_\_\_
Street Address \_\_\_\_\_ ☐ Male ☐ Female Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_
Full-Time Hire \_\_\_\_\_ Hours worked per week \_\_\_\_\_ Marital Status S/M \_\_\_\_\_
Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Are you now actively at work on a full-time basis for this employer? ☐ Yes ☐ No Requested Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_

2 Occupation \_\_\_\_\_ Class \_\_\_\_\_ Annual Salary \_\_\_\_\_
Beneficiary \_\_\_\_\_ Relationship \_\_\_\_\_

3 Table with columns: Last, Full First, M.I., Social Security #, Birth Date, Sex (M/F), F/T Student (Y/N), Disabled (Y/N), POS or HMO only (Primary Care Physician Name/#, OB/GYN Physician Name/#), Existing Patient? (Y/N)

Participating Dentist / Provider Code / Dental Office # \_\_\_\_\_
Aetna/US Healthcare Pharmacy # \_\_\_\_\_
Are you or any of your dependents eligible for Medicare? If Yes: Effective Date (Part A) \_\_\_\_/\_\_\_\_/\_\_\_\_ Effective Date (Part B) \_\_\_\_/\_\_\_\_/\_\_\_\_

Do any of your dependents over 19 attend school on a full-time basis? If Yes: Dependent Name: \_\_\_\_\_
School Name: \_\_\_\_\_ Expected Graduation Date \_\_\_\_/\_\_\_\_/\_\_\_\_

4 Table with columns: HEALTH PLAN, DENTAL PLAN, VISION PLAN, Group#, Plan#, Carrier, Benefit Amount, Waive Covg\*
Includes options for Employee Only, Employee & 1 Child, Employee & Spouse, Family, Over 65/Working FT, Over 65/Retired, Vol. Plan, Life AD&D, Dep. Life, Vol. Life, STD, Vol. STD, LTD, Vol. LTD.

5 OTHER INSURANCE INFORMATION (Must complete this section even if medical coverage waived.)
Do you or your dependents plan to continue any prior health coverage through another employer? ☐ Yes ☐ No
Other Health Insurer Name \_\_\_\_\_ Policy # \_\_\_\_\_
Who is covered ? [ ] Self [ ] Spouse [ ] All Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Term Date \_\_\_\_/\_\_\_\_/\_\_\_\_

CONSENT TO RELEASE MEDICAL INFORMATION: I consent to the release of information and medical records to or from any appropriate government agency, health care practitioner, facility, supplier, or other provider or insurance carrier, as necessary to coordinate patient care and health benefits, to process claims for reimbursement, to monitor the appropriateness of care provided, and to assure compliance with applicable rules. I understand that records and information will not be released by any insurance carrier for any other purposes, or to any other person, except as required by law or with my written consent or the written consent of my legal representative.

CERTIFICATION: I hereby apply, on behalf of myself and each dependent listed above, for the coverage(s) indicated. If accepted, coverage will be provided according to the terms and conditions of the benefit plan(s) between the appropriate carrier(s) and my employer. I agree to be bound by the benefit plan(s) of which this form will become part. I also agree to pay current and future charges for coverage(s) provided in excess of any employer contribution. The recorded answers on this form are to the best of my knowledge and belief full, complete and true as of this date. I further certify that I am the spouse, parent, or legal guardian of the dependents listed above.

\* If I have waived any coverage offered by my employer as indicated above, I hereby certify that I have read and understand the "Waiver of Insurance Coverage" statement on the reverse side of this form.

6 EMPLOYEE SIGNATURE \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_
EMPLOYER SIGNATURE / VERIFICATION \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_