EMPLOYEE ENROLLMENT/CHANGE FORM

For Groups under 51 Lives

Administrative Services by: Planned Administrators, Inc.
PO Box 6927 Columbia, SC 29260
Phone: 800.768.4375

Marketed Exclusively by: Benefit Indemnity Corporation
303 W Allegheny Avenue Towson, MD 21204
Phone: 443.275.7400 www.benefitindemnity.co

NOTICE: A person who knowingly and with intent to defraud files an application or statement of claim containing any false, incomplete or misleading information may be guilty of fraud, which is a crime. I understand and agree to answer all questions and complete all requested information thoroughly and truthfully. I understand that failure to do so may result in loss of coverage or denial of claims for any or all of those persons included on this application.

➢ Each eligible employee must complete the entire form. ➢ This enrollment form must be completed in blue or black ink.

Please choose from the following: ❑ **New Applicant** ❑ **Coverage Change** ❑ **Information Update** ❑ **COBRA Applicant** ❑ **Add/Drop Dependent**

PLEASE FILL OUT THE ENTIRE APPLICATION TO AVOID PROCESSING DELAY.

Applicant Social Security Number: _____ - _____ - _____ Group #: _____

Employer Name: _____

Division and/or Location: _____

APPLICANT

Last Name: _____ First Name: _____ Middle Initial: _____ Date of Birth: _____

Marital Status: ❑ Single ❑ Married Gender: ❑ Male ❑ Female Height: _____ Ft. _____ In. Weight: _____ Lbs.

Have you or any eligible dependent used tobacco products in the past twelve (12) months? ❑ Yes ❑ No

Address: _____ City: _____ State: _____ Zip Code: _____

Home or Mobile Phone: _____ Work Phone: _____

Occupation: _____ Email Address: _____

Date Employed Full-Time: _____ Are you currently employed Full Time? ❑ Yes ❑ No

Please indicate the number of hours worked weekly on a regular basis for this employer: _____

FAMILY INFORMATION (PLEASE COMPLETE FOR ALL PERSONS TO BE COVERED BY THE HEALTH PLAN)

First Name & M.I. (last name if different)	Gender	Date of Birth	Height	Weight	Social Security No.	Email Address
Spouse	❑ M ❑ F	/ /			- -	
Child	❑ M ❑ F	/ /			- -	
Child	❑ M ❑ F	/ /			- -	
Child	❑ M ❑ F	/ /			- -	
Child	❑ M ❑ F	/ /			- -	

COVERAGE INFORMATION

Medical: ❑ Employee ❑ Family ❑ Employee/Spouse ❑ Employee/Child(ren) Requested Effective Date: _____

Do you have other coverage that will remain in place along with this coverage? ❑ Yes ❑ No *(If YES, provide additional info/copy of ID card.)*

REQUIRED MEDICAL INFORMATION

QUESTIONS 1 THROUGH 4 TO BE ANSWERED BY EMPLOYEE, SPOUSE AND ALL DEPENDENTS DESIRING COVERAGE.

1. In the past 24 months, are you or have you, or any of your dependents (spouse and/or any child) to be covered in the plan:

a. Taken medication, received or been advised by a physician to seek treatment, received follow up care, scheduled office visits, lab work or diagnostic services, awaiting results of any diagnostic tests, biopsies or lab work, or been advised of a condition that is recommended to be treated in the next 24 months, been in the hospital or disabled? ❑ Yes ❑ No

REQUIRED MEDICAL INFORMATION (CONT.)

2. Are you or your spouse (whether covered on the plan or not) pregnant? ❑ **Yes** ❑ **No**

If Yes... Due Date: _____ Are you expecting twins or another multiple birth? ❑ Yes ❑ No

Are you having any complications? ❑ Yes ❑ No Are you planning a C-Section? ❑ Yes ❑ No

3. Have you or any eligible dependent ever been declined, postponed, ridered, or rated up for medical, disability or life insurance with any insurance carrier? ❑ **Yes** ❑ **No**

4. In the past five (5) years, have you or any eligible dependent to be covered had any symptoms, diagnosis, consultation, testing, treatment, follow-up care, or taken any medication or received counseling for:

a.	High blood pressure, hypertension or heart condition?	❑ Yes ❑ No
b.	Psychological disorder, substance use disorder, ADD or ADHD?	❑ Yes ❑ No
c.	Back or Neck Pain, arthritis, joint or muscular disorder?	❑ Yes ❑ No
d.	Asthma, emphysema, respiratory or lung disorder?	❑ Yes ❑ No
e.	Circulatory, Vascular, Endocrine or blood disorder?	❑ Yes ❑ No
f.	Neurological disorder or stroke?	❑ Yes ❑ No
g.	Tumor (benign, malignant or otherwise), Cancer?	❑ Yes ❑ No
h.	Diabetes or kidney disorder?	❑ Yes ❑ No
i.	HIV or immune system disorder, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	❑ Yes ❑ No
j.	Serious or Systemic Infection?	❑ Yes ❑ No
k.	Congenital Disorder/Birth Defects?	❑ Yes ❑ No
l.	Hepatitis or Liver Disorder?	❑ Yes ❑ No
m.	Digestive system disorder?	❑ Yes ❑ No
n.	Lupus or Multiple Sclerosis?	❑ Yes ❑ No
o.	Infertility or Reproductive system / genitourinary system disorder?	❑ Yes ❑ No
p.	Organ/Tissue transplant (whether donating or receiving)?	❑ Yes ❑ No

Provide details to "YES" answers on Questions 1-4 including information regarding last doctor visit and/or examination and all medication taken (if more space is needed, attach an additional sheet of paper, sign and date it.)

Question/Letter	Name	Diagnosis	Treatment Start/End Dates	Medications	Treatment/Surgery

Treating Physicians Name(s)	Phone Number	Address

REQUIRED-EMPLOYEE AGREEMENT/AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I understand that the above answers shall be the basis for the Plan Sponsor (the employer shown on page one of application) to issue a Summary Plan Description. I declare all statements contained in this entire form about me and my dependents are true and correct and that no material information has been withheld or omitted. I understand and agree that the Plan Sponsor is not bound by any statement made by or to any agent unless written herein. I agree that no coverage will be effective until the date specified by the Plan Sponsor (the employer shown on page one of application).

I hereby apply for participation in my employer's employee welfare benefit plan (the Plan) for my dependents and myself listed above. To assist the Plan Sponsor with determining my creditable coverage, I also hereby authorize any physician, medical practitioner, hospital, clinic, Veterans administrations facility, other medical or medically related facility, insurance or reinsurance company, pharmacy, pharmacy benefit manager, health plan, or Consumer Reporting Agency, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition, including drug or alcohol abuse, and/or treatment of me or my minor children and other non-medical information of me and my minor children, to release to the claims or third party administrator, any other excess loss insurance carrier designated by the Plan, or its legal representative, any and all such information as required for determination of eligibility for benefits. I also understand that my dependents of legal age, in order to be eligible for benefits, may be required to sign a similar release of medical records for the purpose of determining the accuracy of statements made by me on this application and for the ultimate determination of eligibility for benefits under the Plan. I understand that I may request a copy of this authorization at any time. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I agree that a photographic copy of this authorization shall be as valid as the original, and that this authorization shall be valid for 2 ½ years from the date shown below. I understand the information obtained by use of this authorization may be used by the Plan Sponsor, claims or third party administrator, and any excess loss insurance carrier designated by the plan to determine eligibility for health coverage, and eligibility for benefits under an existing plan, for myself and my dependents. Any information obtained will not be released to any person or organization, except to reinsuring companies or other persons or organizations performing business or legal services in connection with my enrollment for the coverage, for any claim, for medical management purposes, or as may be otherwise lawfully required or as I may further authorize. I also understand that I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.

I authorize my employer to deduct the necessary contribution toward the coverage. I reserve the right to revoke this deduction at any time upon my written notice subject to regulations or law. Coverage is effective only after approval and satisfaction of any probationary period and is contingent upon truthful completion of this enrollment form. In some states, any person who, knowingly and with intent to defraud, submits an application or files a claim containing any materially false information may be guilty of fraud, which is a crime. The Plan Sponsor reserves the right to terminate, modify or rescind coverage on any person because of the person's intentional material misrepresentation or fraud, including but not limited to, information requested in this form relating to me and my dependents.

I authorize Benefit Indemnity Corporation to contact me via the email address provided above with plan information and/or marketing materials that may provide educational information on my health benefits and any additional offers. I understand that my email address will never be shared with unrelated entities.

This enrollment form should not be completed more than 60 days prior to the Plan Sponsor's requested effective date. Date Signed: _____

Print Name: _____ Applicant Signature: _____