

- New Enrollee Coverage Change Waiver (See Section 6)
 COBRA/MSE Enrollee Information Update



GROUP BENEFIT SERVICES, INC.
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EMPLOYEE ELECTION FORM

Every Item Must Be Completed

(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):	
Street Address					Date of Hire		Medical: _____ Life/STD: _____	
City			State	Zip Code	Hours Worked Per Week		Dental: _____ LTD: _____	
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"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Widowed		Date of Marriage		Name of Employer			Annual Salary	
							Effective Date	
							Benefit Class/Occupation	
							GBS Account Number	

2. GENERAL INFORMATION (Complete entire line for all listed)						IF HMO OR POS PLAN			Tobacco Use	Medical	Dental	Vision	Debit Card
	Last Name	First Name	M.I.	Date of Birth	Social Security #	Sex	Primary Care Provider #	Current Patient (Y/N)	Dentist Code	(Y/N)	(Y/N)	(Y/N)	(Y/N)
Self													
Sp/DP													
Child													
Child													
Child													

Are any of your dependents Disabled (Y/N) _____ or Full-Time Student (Y/N) _____ If so, name of dependent _____

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 # _____

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	GBS ADVANTAGEHRA
Carrier: _____ Plan: _____ Group# _____ <input type="checkbox"/> Individual <input type="checkbox"/> Individual & 1 Child <input type="checkbox"/> Individual & Adult <input type="checkbox"/> Individual & Children <input type="checkbox"/> Family <input type="checkbox"/> Comp. to Medicare (Ind. Only and Benefit Coverage Only, Not Eligible for HSA.) <input type="checkbox"/> NONE	Carrier: _____ Plan: _____ Group# _____ <input type="checkbox"/> Individual <input type="checkbox"/> Individual & 1 Child <input type="checkbox"/> Individual & Adult <input type="checkbox"/> Individual & Children <input type="checkbox"/> Family <input type="checkbox"/> NONE	Carrier: _____ Plan: _____ Group# _____ <input type="checkbox"/> Individual <input type="checkbox"/> Individual & 1 Child <input type="checkbox"/> Individual & Adult <input type="checkbox"/> Individual & Children <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	Carrier: _____ Plan: _____ Group# _____ <input type="checkbox"/> Individual <input type="checkbox"/> Individual & 1 Child <input type="checkbox"/> Individual & Adult <input type="checkbox"/> Individual & Children <input type="checkbox"/> Family <input type="checkbox"/> NONE

5. LIFE INSURANCE BENEFICIARY:

Beneficiary Name	Relationship	%

Important - Special Carrier Information/Waiver Information Below - Please Read and Check All That Apply

GBS Advantage HRA
 I understand that my elections are binding for the entire Plan Year and cannot be revoked, modified or amended unless due to a limited family status change. Under penalty of perjury I agree to use the debit card solely for the purchase of eligible expenses not covered by any other plan. I am responsible for providing proof to support reimbursed expenses and agree that any reimbursed expenses later discovered to be ineligible may be deducted from my paycheck by my employer. I authorize the release of claims information to my employer and Group Benefit Services, Inc.

6. 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.

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

CERTIFICATION: I hereby enroll, on behalf of myself and each dependent listed above, for the coverage indicated. If this Form is accepted, coverage will be provided according to terms and conditions of the contract between the carrier and my employer. I agree to pay current and future charges for the coverage provided in excess of any employer contribution. Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I have carefully read this Form and agree to its terms. The recorded answers on this Form are, to the best of my knowledge and belief, full, complete and true as of this date. 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 as defined by the IRS.

If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a membership services representative before signing this enrollment card.

EMPLOYEE SIGNATURE: _____ DATE: _____
 EMPLOYER SIGNATURE/VERIFICATION: _____ DATE: _____