GROUP ADMINISTRATORS, LTD.
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ENROLLMENT/REINSTATEMENT APPLICATION

Employer _____ Div. _____

Social Security No. _____

Employee Name _____

Address _____

City _____ State _____ Zip Code _____

Date of Birth _____ Sex _____ (M / F)

Marital Status _____ Single, Married, Divorced, Widowed

Date of Hire _____ Job Title _____

Full Time ☐ Part Time ☐ Salary _____

ELECTION CHOICES (Please Complete)				
Coverage(s)	**Type**	**Plan**	**PPO/POS**	**Effective Date**
Medical				
Dental				
Vision				
STD				
Type: 1 = Single (EE); 2 = EE+Spouse; 3 = EE+Children; 4 = Family				
Plan Choice: 1 = PPO Plan; 2 = POS Plan; 3 = Out-of-Area				
PPO/POS Choice: Those choices offered by the Plan.				

ELECTION CHOICES (Please Complete)			
Coverage(s)	**Yes/No**	**Volume**	**Effective Date**
Life/AD&D			
Optional Life			
Dependent Life			
LTD			
Section 125			
EAP			
You may be required to complete additional applications or forms.			

EMPLOYEE/DEPENDENT COVERAGE ELECTION:

☐ YES, I request to participate in my Employer's present benefit plan or as it may be amended in the future. I request coverage for ☐ myself only, or ☐ myself and my dependents (please list below). I hereby authorize payroll deductions for my share of the cost, if any, of the benefits to which I may become entitled. I have read the provisions on the reverse side of this form concerning special enrollment provisions to which I or my dependents may be entitled at a later date.

Certificate of Prior Credible Coverage attached: ☐ Yes ☐ No

☐ NO, I decline to participate in the benefit plan. If I later desire coverage for myself or my dependents, I understand that all provisions of the Plan's pre-existing condition provision will be applied. I have read the provisions on the reverse side of this form concerning special enrollment provisions to which I or my dependents may be entitled at a later date.

	Name	Date of Birth	Rel.*	Social Security Number	Covered by Other Insurance**	*If Attending School* Name of School / University
1.					☐ YES ☐ NO	
2.					☐ YES ☐ NO	
3.					☐ YES ☐ NO	
4.					☐ YES ☐ NO	
5.					☐ YES ☐ NO	

* 1 - Wife 2 - Husband 11 - Daughter 12 - Son

** If covered by other insurance, please provide the name of the carrier, company, type of coverage and effective date.

BENEFICIARY INFORMATION:

At the time of my death, the proceeds of any group life policies through my employer, as well as any existing payable benefits, should be paid to:

Name _____ Relationship _____

I certify that the answers I have given to the questions of this application form are complete and true to the best of my knowledge. Any misstatements may be used as a basis for revision of benefits.

Signature of Employee _____ Date _____

Important Enrollment Information

Effective for all Plan Years commencing on or after July 1, 1997

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Group health plans may not establish eligibility rules based on any of the following health status-related factors; medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), or disability.

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Group plans are required to provide special enrollment periods for individuals who do not enroll in the plan at the first opportunity because of other coverage, and subsequently lose this other source of coverage. 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 the plan, provided you request such enrollment in writing within 30 days after your other coverage ends.

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In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may 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.

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