Enrollment/Change/Termination Form

Please print and sign form after completing.
All eligible employees MUST complete this form.

- ☐ New Enrollment
- ☐ Open Enrollment
- ☐ Special Enrollment
- ☐ Change
- ☐ Termination

EMPLOYEE INFORMATION **Please indicate language preference:** **English** **Spanish**

Group Number	Employer Name	Division/Location	Date of Hire/Full Time	Effective Date

Social Security Number	Last Name	First Name	M.I.	Date of Birth

Mailing Address: Street	City	State	Zip	Gender ☐ Male ☐ Female

Home Phone	Work Phone	Annual Salary	Hours Worked per Week	Marital Status ☐ Single ☐ Divorced ☐ Widowed ☐ Married ☐ Legally Separated	Date of Marriage

Health Plan Election

☐ Initial Election		☐ Change Election Effective Date:		If you are Medicare Eligible, please indicate which parts…	☐ Decline Coverage - If declining coverage, select reason below, then sign and date on the next page:
Life/AD&D ☐ Employee ☐ Dependent(s)	Medical ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family	Dental ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family		☐ Part A ☐ Part B ☐ Part D	☐ Other group coverage ☐ Medicare/Medicaid ☐ Other:

Special enrollees: I am submitting proof (Certificate of Health Plan Coverage) with this enrollment. ☐ Yes ☐ No

EMPLOYEE TERMINATION

☐ Terminate all coverage for employee and his/her dependents Effective Date of Termination:

Reason for Termination:

☐ Loss of Employment ☐ Reduction in Hours (employee no longer eligible) ☐ Voluntary Termination of Coverage (employee still employed) ☐ Medicare Enrollment (employee still employed)

DEPENDENT INFORMATION (All eligible dependents MUST be listed below)

☐ **Change coverage on ALL dependents listed below.** Effective Date of Change: ☐ Divorce or legal separation pending ☐ Over age dependent listed below

Applicant Relation	Name: Last	First	M.I.	Date of Birth	Gender	Social Security Number	Coverage	If declining coverage, indicate reason
Spouse					☐ Male ☐ Female		☐ Enroll ☐ Term	☐ Other group coverage ☐ Medicare/Medicaid ☐ Other:
Child					☐ Male ☐ Female		☐ Enroll ☐ Term	☐ Other group coverage ☐ Medicare/Medicaid ☐ Other:
Child					☐ Male ☐ Female		☐ Enroll ☐ Term	☐ Other group coverage ☐ Medicare/Medicaid ☐ Other:
Child					☐ Male ☐ Female		☐ Enroll ☐ Term	☐ Other group coverage ☐ Medicare/Medicaid ☐ Other:
Child					☐ Male ☐ Female		☐ Enroll ☐ Term	☐ Other group coverage ☐ Medicare/Medicaid ☐ Other:

OTHER COVERAGE INFORMATION				
Is there any other coverage in effect for yourself or for any of your eligible dependents? ☐ Yes ☐ No **Is "Yes", please complete the following:**				
Name of Primary Insured with Other Coverage	Social Security Number	Relationship to Applicant	Employer Name	Employer Phone Number
Name and Address of Other Coverage	Coverage Effective Date	Who is Covered? ☐ Self ☐ Spouse ☐ Child(ren)	Type of Coverage ☐ Medical ☐ Rx	

LIFE AND AD&D BENEFICIARY INFORMATION (Applicable only when offered by my employer)					
☐ Initial Designation	☐ Change Designation – Effective date:				
Primary Beneficiary	Name: Last	First	M.	Social Security Number	Relationship to Applicant
	Mailing Address: Street	City	State	Zip	Primary Phone
Secondary Beneficiary	Name: Last	First	M.	Social Security Number	Relationship to Applicant
	Mailing Address: Street	City	State	Zip	Primary Phone

I acknowledge that the available coverages have been explained to me by my employer. I hereby apply for the coverage now being offered to me and my dependent(s), if any, as shown above. If accepted as a group member, my employer is authorized to deduct the appropriate amount from my earnings and remit to AgBenefits. I hereby declare that all answers above are true and complete and that any material misstatements or failure to report information may be used as the basis for rescission of coverage for me and my dependent(s), if any, from the original date. I further understand that if the coverage applied for becomes effective, I will be subject to all the terms and provision of the group plan(s). I authorize any physician, medical practitioner, hospital, clinic or other medical related facility, insurance company or other organization, employers or other person that has any information available as to my health or that of any member of my family to give to AgBenefits or its legal representative any such information. I was not induced or pressured into declining coverage because of health status or that my dependent(s), if any. I further understand that in the event I should decide to apply for coverage at a later date, such subsequent application shall be subject to the applicable terms and conditions of the group plan(s), which may require additional limitations and waiting periods. I understand that I may not be able to apply for this coverage until an annual Open Enrollment period. A photocopy of this authorization shall be as valid as the original.

Employee Signature ____________ Date ____________ Authorized Employer Signature (REQUIRED) ____________ Date ____________

WARNING

It is unlawful to knowingly provide false, incomplete or misleading facts or information for the purpose of defrauding or attempting to defraud. Penalties may include imprisonment, fines, denial or coverage and civil damages.

After filling out the form, please sign and date above, and return to your employer's human resource department.