Employee Enrollment Application

Administered By: Gettysburg Benefits Administrators, Inc.
P.O. Box 1060 Gettysburg, PA 17325-1060

☐ Delta Dental (2-4 only; for 10+ use SBA forms)
☐ National Vision Administrators (NVA)

☐ New Enrollment
☐ Add Dependent

Please complete each section of this application in ink.

Name of Employer:

Shaded Area For Office Use Only	Group #:	Eff. Date:	Processed by:	Date:

Applicant Information (Employee)

Your Name (last, first , initial):			**Social Security Number:** - -
Gender: ❑ Male ❑ Female	**Date of Birth** (mm/dd/yy):	**Date of Full-Time Employment:**	**Weekly Hours:** _____/ per week
Home / Mailing Address (Street or Route):			**City, State, Zip Code**:
Phone Number::	**Email Address:**	**Marital Status:** ❑Single ❑Married ❑Widowed ❑Divorced ❑Legally Separated	
Are you covered by Workers' Compensation: ❑ Yes ❑ No	**Job Title/Duties**:	**Insurance Class**:	

Family Member Information (If you choose not to enroll all your eligible family members, you must complete a waiver form)

List all family members you wish to enroll, including any child who is under age 26; or who is medically certified as disabled and dependent on parent for support (copy of certification required).

	Status	**Gender**	**Date of Birth (mm/dd/yy)**	**Social Security #**
Applicant/Employee	SELF			
Family Member's Name (last if different than employee, first , initial)				
	❑Spouse ❑Child	❑ M ❑ F		
Family Member's Name (last if different than employee, first , initial)				
	❑Child	❑ M ❑ F		
Family Member's Name (last if different than employee, first , initial)				
	❑Child	❑ M ❑ F		
Family Member's Name (last if different than employee, first , initial)				
	❑Child	❑ M ❑ F		
Family Member's Name (last if different than employee, first , initial)				
	❑Child	❑ M ❑ F		
Family Member's Name (last if different than employee, first , initial)				
	❑Child	❑ M ❑ F		

Type of Enrollment		*To Add Dependent Please Provide Qualifying Event Information*
Dental Coverage ❑ Self ❑ Spouse ❑ Child/Children	**Vision Coverage** ❑ Self ❑ Spouse ❑ Child/Children	**Change current enrollment because of the following event:** ❑ Marriage ❑ Divorce ❑ Birth ❑ Involuntary loss of coverage ❑ Death ❑ Court order (copy of court order required) ❑ Other _____ Date event occurred: _____/_____/_____ mm dd yy

To Request Coverages

(Please read and sign the below ***statement of understanding***):

By signing this application, I represent that all my answers are complete and accurate, and that I understand and agree to the following conditions:

• I agree to abide by all of the terms and conditions of the group policy.

• If I decline to enroll any eligible family member on this application or a newly-eligible family member at a later date, I must complete, sign, and return to the insurer the Employee's Waiver of Coverage area of this form (located below).

• No independent producer, agent or employee of the insurer or of my employer can change any part of this application or waive the requirement that I answer all questions completely and accurately.

• The insurer may, at its discretion, request supplemental information from me, any family member listed on this application or any health care provider.

• On behalf of myself and all enrolled family members, I understand if the insurer discovers any intentional misrepresentation, omission or concealment of fact in obtaining coverage that was or would have been material to the insurer's acceptance of a risk, extension of coverage, provision of benefits or payment of any claim, or any fraudulent misstatements or activity, the insurer may take action against my employer, including but not limited to increasing premiums or retroactive cancellation of coverage.

• If this application is approved, coverage for myself and any eligible family members named on this application will begin on the date assigned by the insurer.

• I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law. I understand that upon written request I may revoke this authorization except to the extent that action has already been taken in reliance on this authorization. This authorization expires when coverage terminates. I understand that a facsimile or photocopy of this form is as valid as the original, and that I have a right to receive a copy of this form upon request.

• As proof of status of employment, I authorize my employer to release to the insurer appropriate documents, including but not limited to, W-2 Wage and Tax Statements and other wage and tax summaries or forms.

• I understand that it is my responsibility to report to my employer any changes in the eligibility of me or the individuals listed or any change to the information provided on this application.

• I authorize my employer to deduct any required contribution for the insurance coverage from my earnings.

• The master group policy, issued in conjunction with the master group application, is the document that sets forth all terms of my coverage, and no independent producer, agent or other person can change the terms of the master group policy, any of its amendments, or this application, except with an amendment issued expressly for that purpose and signed by an authorized officer of the insurer.

• Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties and may result in termination of benefits.

• I agree that a facsimile or photocopy of my signature will serve the same as an original.

• I understand that this application will become part of the contract between the insurer and my employer.

• I affirm that I have reviewed all answers given on this application and, regardless of whether an independent producer or other person has filled out the answers for me, I verify that the answers are true and complete.

X _____

Applicant's Signature *Date*

Employee's Waiver of Coverage - To Decline Coverages (Please read and sign below.)

I understand that I am eligible for benefits under the group insurance plan(s) for employees of the employer named above. Benefits under such plan(s) have been explained to me in detail. After careful consideration, I decline coverage(s) not selected above for myself and/or my eligible dependents and waive all claims to benefits under any of the plan(s).

Reason for waiving coverage:

❑ Coverage through my spouse's employer
❑ Declined for contributory benefits (employee pays portion of premium)
❑ Other reason

X _____

Applicant's Signature *Date*

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) NOTICE

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 this plan, provided that you request enrollment within 30 days after your other coverage ends. 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.