

Group & Pension Administrators, Inc. Enrollment Form

- New Employee
 Late Enrollee
 Special Enrollee
 Reinstatement
 Life Only

***** ATTACH CERTIFICATE OF COVERAGE FOR PREEXISTING CREDITS AND/OR TO QUALIFY FOR SPECIAL ENROLLMENT PERIODS*****

EMPLOYER: PLEASE COMPLETE THIS SECTION

Employer: _____ (Full Time)
 Employment Date: _____
 Plan # _____ Location # _____ Dept/Div # _____ Effective Date: _____
 Annual Earnings: _____ Hourly (If Applicable) _____
 _____ Salary (If Applicable) _____
 Life Insurance Amount: _____ Supplemental Life Amount: _____
EMPLOYEE: PLEASE TYPE OR PRINT WITH BALLPOINT PEN

Name: _____ (LAST) _____ (FIRST) _____ (MIDDLE) _____ (SOCIAL SECURITY NO.)

Address: _____ (CITY) _____ (STATE) _____ (ZIP)

Job Title: _____ Marital Status: Single Married Divorced Widowed Legally Separated

Name of Life Insurance Beneficiary: _____ (Last) _____ (First) _____ (Middle) _____ (Relationship)

CHOICE OF PLAN OPTION (if applicable): _____
LIST ALL PERSONS TO BE COVERED BELOW:

FAIR/ OVEE	LAST	FIRST	M.I.	RELATIONSHIP	BIRTHDAY			SEX M/F	SOCIAL SECURITY NUMBER	MEDICAL/DENTAL		DEP LIFE		OTHER	
					MO	DAY	YEAR			Yes	No	Yes	No	Yes	No
				SELF											
SPOUSE															
CHILD															
CHILD															
CHILD															
CHILD															

1. Are your Dependent children (to be covered) residing with you? Yes No If no, provide details.
2. Do you claim your Dependent children (to be covered) as exemptions on your Federal Income Tax Return? Yes No
3. Are any Dependent children (to be covered) over age 19 and full-time students (12 hour minimum)? Yes No
 If yes, submit proof of full-time student status from College Registrar with enrollment form and every semester thereafter.
4. Are you or your dependents insured under any group health coverage? Yes No If yes, provide name and address of other insurance company, name of insured person(s), policy and group numbers. _____
5. Do you or any of your dependents have Medicare? Yes No If yes, provide name of insured person _____ effective date _____ and Medicare number (from Medicare Card) _____

ACCEPTANCE OF COVERAGE

I have read and understand the Enrollment Disclosure and accept this Agreement. Until revoked by me in writing, I authorize deductions from my paycheck of an amount to be determined periodically by my Employer.

Signature of Employee (Yes, I accept): _____ Date: _____

WAIVER OF COVERAGE

Although I (and my eligible Dependents) have been given the opportunity to enroll in the Health Plan offered by my Employer, I decline to enroll.

- Self

Dependents listed by name _____

I confirm that I was not pressured into declining coverage, but elect by my own accord to decline such coverage. I have read and understand the Enrollment Disclosure and accept this Agreement. Coverage is being declined for the following reason:

- Have other coverage, Name of Plan _____ Type of Coverage Medical Dental
 Do not choose to make contribution Other _____ Date: _____
 Signature of Employee (No, I do not accept): _____

ADMINISTRATOR USE: Approved Effective Date: _____ By: _____