

BENEFIT MANAGER COMPLETES THIS SECTION:

Name of Association:		Subgroup Number:
New Enrollment: <input type="checkbox"/>	Open Enrollment: <input type="checkbox"/>	Enrollment Change: <input type="checkbox"/>
Name Change: <input type="checkbox"/>	Reinstatement: <input type="checkbox"/>	Rehire: <input type="checkbox"/>
Effective Date:	Change Effective Date:	Employee Hire Date:
Authorized Benefit Manager's Signature:		Date:

(SECTION 1) EMPLOYEE INFORMATION: Please print (or type)

Last Name:	First Name:	MI:
Address:	City:	State: Zip Code:
Home Phone #:	Email:	
Social Security #:	Date of Birth:	Gender:
Marital Status:	Date of Marriage:	Alternate Phone #:

(SECTION 2) DEPENDENT COVERAGE: List spouse and all eligible dependent children applying for coverage under this plan.

ADD or DROP	Name	Gender	Select applicable coverage:			Relationship to Applicant	Date of Birth	Social Security Number
			Health	Dental	Vision			
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Is Dependent Disabled?	Name:							Effective Date:

(SECTION 3) ELECTION OF COVERAGE: Check box to indicate network choice & level of coverage for each option.

	PPO Plan Select One: <input type="checkbox"/> CareFirst <input type="checkbox"/> OneNet <input type="checkbox"/> PHCS	Network Only Plan Select One: <input type="checkbox"/> CareFirst <input type="checkbox"/> PHCS	Qualified High Deductible Health Plan: <input type="checkbox"/> CareFirst <input type="checkbox"/> OneNet <input type="checkbox"/> PHCS	Kaiser	MetLife Dental Plan Select One: <input type="checkbox"/> Premium <input type="checkbox"/> Standard	UHC Vision Plan	Life Insurance*	Legal Resources	Flexible Spending Account**	Health Savings Account**
Employee Only	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Employee + Child(ren)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Employee + Spouse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Employee + Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retiree (Medicare Part B required for reduced premium rate.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*Additional application must be completed (available at <http://www.amhic.com> – click on “Forms & Links” tab)

**Additional application must be completed. If you are enrolling in the Qualified High Deductible Health Plan/Health Savings Account and enroll in the FSA you will automatically be enrolled in the Limited Use FSA.

(SECTION 4) OTHER HEALTH INSURANCE INFORMATION:

Complete this section if you or any of your dependents are covered by any other Health Care Plan.

Name of Policyholder:		Relationship to You:			
Social Security Number of Covered Person:		Date of Birth:			
Carrier:	Policy Number:			Effective Date:	
Type of Plan:					
Group: <input type="checkbox"/>	Individual: <input type="checkbox"/>	Medicare*: <input type="checkbox"/>	Medicaid*: <input type="checkbox"/>	Champus: <input type="checkbox"/>	Other:
Is the Covered Person Retired?		If YES, Enter Date of Retirement:		Cancellation Date, If Applicable:	

*Copy of Card Required

(SECTION 5) WAIVER OF COVERAGE FOR BENEFITS:

Mandatory signature required below if you are waiving or declining coverage for any of the benefits listed below.

I hereby waive or decline coverage under my employer's group benefits plan. Please check all applicable boxes below:	
<p>MEDICAL</p> <p><input type="checkbox"/> PPO <input type="checkbox"/> Network Only <input type="checkbox"/> Kaiser</p> <p><input type="checkbox"/> Qualified High Deductible Health Plan</p>	<p>OPTIONAL BENEFITS</p> <p><input type="checkbox"/> Dental – MetLife <input type="checkbox"/> Vision – UHC</p> <p><input type="checkbox"/> Life Insurance – MetLife <input type="checkbox"/> Legal – Legal Resources</p> <p><input type="checkbox"/> Flexible Spending Account <input type="checkbox"/> Health Savings Account</p>
<p>I hereby certify that I have been given the opportunity to participate in the group insurance plan provided by my employer. If I and/or any of my eligible dependents desire to apply for insurance at a later date, I will be required to wait until the annual open enrollment period unless I experience a qualifying status change. Any pre-existing conditions specified in the certificates of coverage may apply.</p>	
<p>Employee's Signature: _____ Date: _____</p>	

(SECTION 6) EMPLOYEE CERTIFICATION:

<p>I hereby apply for group benefits under my employer's group plan(s) and authorize payroll deduction, if required, for the cost of coverage. I understand my enrollment and/or changes are IRREVOCABLE unless I have a qualifying status change. My elections will remain in effect for the remainder of the calendar year unless I have a qualifying status change. I understand I must request such changes within thirty-one (31) calendar days of the qualifying status change. I certify that the information given on this enrollment form is complete and correct, and I understand that if the information is not complete and correct, this coverage may be retroactively terminated.</p>	
<p>Employee's Signature: _____ Date: _____</p>	
<p>Print Name: _____</p>	