

# Enrollment Form



Send to: AssureCare  
 340 Quadrangle Drive  
 Bolingbrook, IL 60440  
 Phone: (630) 759-1311  
 Fax: (630) 759-5219

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

<input type="checkbox"/> <b>New Enrollment</b>	<input type="checkbox"/> <b>Declination of Coverage</b> (All or part of coverage) *Signature required below	
<input type="checkbox"/> <b>Enrollment Change</b>	Effective Date of Enrollment Change	Reason for Enrollment Change

I. Employer Information		
Employer's Name	Location Number	PPO Name

II. EMPLOYEE INFORMATION					
Social Security Number	Group Number	Group Name			
Last Name	First Name	Middle Initial	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date Of Birth	
Physical Address		City	State	Zip	
Date of Full Time Employment	Effective. Date Of Coverage	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other			

III. Coverages Requested			
<input type="checkbox"/> <b>Medical</b>	<input type="checkbox"/> Single	<input type="checkbox"/> Family	<input type="checkbox"/> Single+1
<input type="checkbox"/> <b>Denta</b>	<input type="checkbox"/> Single	<input type="checkbox"/> Family	<input type="checkbox"/> Single+1
<input type="checkbox"/> <b>Vision</b>	<input type="checkbox"/> Single	<input type="checkbox"/> Family	<input type="checkbox"/> Single+1

IV. Additional Coverages		
<input type="checkbox"/> <b>Life</b> (Amount) \$ _____		
(Beneficiary) _____		
<input type="checkbox"/> <b>Dep Life</b>	<input type="checkbox"/> <b>Supp Life</b>	<input type="checkbox"/> <b>AD&amp;D</b>
<input type="checkbox"/> <b>LTD</b>	<input type="checkbox"/> <b>STD</b>	
<input type="checkbox"/> <b>Other</b> (describe) _____		

*\*For Family and Single +1 Enrollment list below all eligible dependents*

V. Dependents							
First Name	Last Name <small>(if different than employee)</small>	MI	Sex	Date of Birth	Effective Date of Coverage	Relationship to Employee	Check if Full Time Student & List School Attending.
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>

VI. Authorized Signature	
<p>I hereby apply for group benefits to which I am entitled or to which I may become entitled under the terms of the group plan or policies sponsored by my employer. I authorized the deduction from my earnings of any contribution I am required to make toward the cost of this group benefit plan. I understand that unless otherwise specified, I must be actively at work before any coverage for which I applied becomes effective.</p>	
	Date _____

**VII. WAIVER OF EMPLOYEE GROUP COVERAGE**

*This is to certify that I have been given an opportunity to participate in the group benefit plan offered by my employer and that I have refused to participate in the following coverages for which I am eligible:*

Employee Coverages			Dependent Coverages	
<input type="checkbox"/> Life	<input type="checkbox"/> Acc. Death & Dismemberment	<input type="checkbox"/> Vision	<input type="checkbox"/> Dependant Life	<input type="checkbox"/> Dental
<input type="checkbox"/> Medical	<input type="checkbox"/> Long Term Disability	<input type="checkbox"/> Supplemental Life	<input type="checkbox"/> Medical	<input type="checkbox"/> Vision
<input type="checkbox"/> Dental	<input type="checkbox"/> Short Term Disability	<input type="checkbox"/> Other (Describe)	<input type="checkbox"/> Other (Describe)	

Reason for refusing coverage:

If refusing coverage because of spouse's coverage, please indicate spouse's employer and insurance carrier:	Spouse's Employer: _____	Insurance Co: _____
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*I fully understand that by this refusal I will not be entitled to any benefits under these coverages and that, if I desire to participate in such coverages at a later date, I must satisfy special enrollment rules of the plan or I will not be able to obtain coverage in the future. If my employer offers late enrollment, I understand my coverage may be subject to a preexisting conditions clause.*

	Date _____
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