

Enrollment Form



Send to: AssureCare
 13700 Watertower Circle, Suite D
 Plymouth, MN 55441
 Phone: (800) 328-0927
 Fax: (763) 383-4880

Date: ____/____/____

| | | |
|---|---|------------------------------|
| <input type="checkbox"/> New Enrollment | <input type="checkbox"/> Declination of Coverage (All or part of coverage) *Signature required below | |
| <input type="checkbox"/> Enrollment Change | 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 | | | | IV. Additional Coverages | | |
|---|---------------------------------|---------------------------------|-----------------------------------|--|---|--|
| <input type="checkbox"/> Medical | <input type="checkbox"/> Single | <input type="checkbox"/> Family | <input type="checkbox"/> Single+1 | <input type="checkbox"/> Life (amount) | <input type="checkbox"/> LTD | <input type="checkbox"/> STD |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Single | <input type="checkbox"/> Family | <input type="checkbox"/> Single+1 | <input type="checkbox"/> Dep Life | <input type="checkbox"/> Supp Life | <input type="checkbox"/> AD&D |
| <input type="checkbox"/> Vision | <input type="checkbox"/> Single | <input type="checkbox"/> Family | <input type="checkbox"/> Single+1 | <input type="checkbox"/> Other (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 | |
|--|------|
| 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. | |
| Employee Signature <small>(sign here if applying for any or all coverages)</small> | Date |

| VII. WAIVER OF EMPLOYEE GROUP COVERAGE | | | | |
|--|---|--|---|---------------------------------|
| <i>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:</i> | | | | |
| 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: |
|---|--------------------|---------------|

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.

| | |
|--|------|
| Employee Signature <small>(sign here if waiving any offered coverages)</small> | Date |
|--|------|