Enrollment Form

Date: _____/_____/_____

Send to: AssureCare
1742 Georgetown Road Suite E
Hudson, OH 44236
Phone: (330) 528-3929
Fax: (330) 342-1642

☐ **New Enrollment**	☐ **Declination of Coverage** (All or part of coverage) *Signature required below	
☐ **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 ☐ M ☐ F	Date Of Birth
Physical Address		City	State	Zip
Date of Full Time Employment	Effective. Date Of Coverage	Marital Status ☐ Single ☐ Married ☐ Other		

III. Coverages Requested

☐ **Medical**	☐ Single	☐ Family	☐ Single+1
☐ **Dental**	☐ Single	☐ Family	☐ Single+1
☐ **Vision**	☐ Single	☐ Family	☐ Single+1

IV. Additional Coverages

☐ **Life** *(amount)*	☐ **LTD**	☐ **STD**
☐ **Dep Life**	☐ **Supp Life**	☐ **AD&D**
☐ **Other** *(describe)*		

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

V. Dependents

First Name	Last Name (if different than employee)	MI	Sex	Date of Birth	Effective Date of Coverage	Relationship to Employee	Check if Full Time Student & List School Attending.
							☐
							☐
							☐
							☐

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 *(sign here if applying for any or all coverages)*	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	
☐ Life	☐ Acc. Death & Dismemberment	☐ Vision	☐ Dependant Life	☐ Dental
☐ Medical	☐ Long Term Disability	☐ Supplemental Life	☐ Medical	☐ Vision
☐ Dental	☐ Short Term Disability	☐ Other *(Describe)*	☐ 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 *(sign here if waiving any offered coverages)*	Date