Group Insurance Service Center, Inc.

APPLICATION FOR GROUP COVERAGE

You or your eligible dependents may not be covered if you enroll more than 30 days after the day you complete the waiting period for coverage.

Employer Name:_____

Occupation/ Title:_____ Location/ Divison:_____ Hours Worked/Week_____ Date of Hire: ____/____/____

Employee Name: _____ Soc Sec #: _____ Phone#:_____

Street Address:_____ City:_____ State:_____ Zip:_____

Male ☐ Female ☐

Date of Birth:____/____/____

Check One: Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated ☐ Separated ☐

If divorced or legally separated, please give date_____

If family coverage, attach copy of divorce decree or separation agreement.

HEALTH PLAN

EFFECTIVE DATE:_____

Coverage desired: ☐ EMPLOYEE ONLY ☐ EMPLOYEE + SPOUSE ☐ EMPLOYEE + CHILD(REN) ☐ FAMILY

Choose Plan: _____

List all eligible dependents that you wish to cover:

FIRST NAME	LAST NAME		DOB mm/dd/yr	Relationship	Dependent Social Security #
		Male ☐ Female ☐	/ /	*Spouse*	- -
		Male ☐ Female ☐	/ /		- -
		Male ☐ Female ☐	/ /		- -
		Male ☐ Female ☐	/ /		- -
		Male ☐ Female ☐	/ /		- -

Are you or any family members covered by any other medical plans? ☐ Yes (if yes, please fill in below) ☐ No

NAME	EMPLOYER	ADDRESS	CARRIER

ACCEPTANCE I apply for coverage and understand coverage will be effective when I have met the eligibility rules in the Plan. I agree that a copy of my signature on this form may be used and authorize any deductions required of me for this coverage from my salary. I state that the information I have furnished above, to the best of my knowledge and belief, is true, correct and complete.

ACCEPTANCE SIGNATURE **DATE**

DECLINATION The benefits have been explained to me and I decline to participate in the Health Plan. I understand that I may not be able to obtain coverage in the Plan at a later time. I will review and sign the special enrollment explanation being provided under separate cover.

DECLINATION SIGNATURE **DATE**