2015 – 2016 MEDICAL ENROLLMENT FORM

Please complete this form in its entirety. Provide a checkmark next to your elected benefit, or next to "decline" if you are not electing the benefit. Please return this form by the due date, even if you are declining coverage.

For HR Completion
Effective Date: _____

Client Name: _____

Employee Name: _____

SSN _____ Date of Hire _____ Date of Birth _____

Occupation _____ Marital Status _____ Gender _____

Phone _____ Email Address _____ Hours worked per week _____

Address _____ City _____ ST ____ ZIP _____

Medical

___ I elect medical coverage
___ I decline medical coverage
If declining, provide reason below:

Coverage Level *(Choose 1)*
__ Employee
__ Employee + Spouse
__ Employee + Child(ren)
__ Family

Plan Design Selected *(Choose 1)*

Reason for decline:

☐ Spouse's Employer's Plan ☐ Individual Plan ☐ Medicare ☐ Medicaid ☐ COBRA from Prior Employer

☐ VA Eligibility ☐ I (we) have no other coverage at this time ☐ Other: _____

Do you or any family member have other group health coverage? ☐ Yes or ☐ No Coverage: ☐ Family or ☐ Single

If yes and family member will be covered on the Lifestyle Plan,
please complete Coordination of Benefit questionnaire to prevent delay of claims processing.

Plan participants will receive up to a $500 deductible credit for participating in the Lifestyle Healthy Rewards Wellness Program.

Dependant Information

Name	**Relationship** (Spouse, Son or Daughter)	**DOB**	**Shirt Size ***

*** Please complete above adult shirt size to receive your complimentary Lifestyle Wellness Shirt at renewal or sold case.**

Authorization

As an employee, I hereby apply for, or waive (if indicated), group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary.

Signature: _____ **Date:** _____