

| | | | |
|---------------------------------------|--------------------------|---|-----------------------|
| EMPLOYER USE ONLY | | Date of Hire: _____ | |
| <input type="checkbox"/> New Employee | | Effective Date: _____ | |
| <input type="checkbox"/> Change | | Group: F1013 | |
| Division: _____ | | | |
| Employee's Name: | | Last | First |
| | | | Middle |
| Employee's Street Address | | City | State |
| | | | Zip Code |
| Date of Birth | | Do You Have Other Medical Insurance? | |
| | | | |
| E-mail Address | Cell Phone Number | Home Telephone Number | Male OR Female |
| | () | () | |

COVERAGE REQUESTED

| | | |
|--|---|--|
| Medical: <input type="checkbox"/> Single <input type="checkbox"/> Family | <input checked="" type="checkbox"/> HPS Solutions/FABOH Advantage/Trilogy | Plan Option: <input type="checkbox"/> General <input type="checkbox"/> Transit <input type="checkbox"/> Fire <input type="checkbox"/> Police |
| STATUS: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time | MARITAL STATUS: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced | |

COMPLETE THE FOLLOWING INFORMATION FOR EACH PERSON TO BE COVERED

| All Dependents must meet the plan definition of an eligible dependent | | | | | |
|---|--------------|-----------|------------|-----|------------------------|
| | Relationship | Full Name | Birth Date | Sex | Social Security Number |
| 01 | Self | | | | |
| 02 | Spouse | | | | |
| 03 | | | | | |
| 04 | | | | | |
| 05 | | | | | |
| 06 | | | | | |
| 07 | | | | | |
| <p>Are you or any of the above dependents covered under another group health policy? <input type="checkbox"/> Yes <input type="checkbox"/> No If 'Yes', please name those covered under the other policy. Are you required by a court decree to cover any of the above listed dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, please attach a copy of the court papers indicating the requirement.</p> | | | | | |

OTHER POLICY NUMBER AND ADDRESS OF CARRIER:

| |
|----------------------------------|
| Health Insurance Carrier: |
| Policy Number: |
| Insured: |
| Members Covered: |
| Carrier: |
| Address: |

Complete this section if making changes other than initial or open enrollment: (Specify change below and update in appropriate section of form.)

| | |
|---------------------------|--|
| Effective date of change: | |
|---------------------------|--|

Reason(s) for change:

- Employee name change
- Employee address change
- Job location change
- Return to work
- Marriage; Date of marri
- Divorce; Date of divor
- Add dependent(s); List on page one
- Remove dependent(s)

| | | | |
|-------------|--|---------|--|
| List names: | | Reason: | |
|-------------|--|---------|--|

- Voluntarily terminate coverage

| | |
|--------------|--|
| List reason: | |
|--------------|--|

- Employment termination

| | |
|---------------------------|--|
| List date of termination: | |
|---------------------------|--|

- Other

| | |
|----------|--|
| Explain: | |
|----------|--|

- Eligible for Medicaid/CHIP subsidy
- Loss of eligibility for Medicaid/CHIP subsidy

I hereby authorize any provider of health care services, claim administrators, insurers, reinsurers, and others who have a legitimate need for such information for the purpose of review, investigation, or evaluation of a claim, to supply each other with information about my health status and health care services provided to me. I agree that a photographic copy of this authorization is as valid as the original. I realize that false information or omissions in this application may result in cancellation of coverage and may be grounds for the plan's sponsor to collect damages. I authorize payroll deductions, if applicable, for my share of the premiums.

Employee Signature: _____ Date: _____

COVERAGE WAIVER SECTION Complete this section only if you are **NOT** electing coverage(s)

Check appropriate box(es):

- Because of other medical coverage, I am waiving medical coverage for:
 - Myself (I have no eligible dependents);
 - Myself & All Eligible Dependents;
 - My Spouse only;
 - All Eligible Dependents.
- I am waiving medical coverage and do not have coverage under another plan.

Employee Signature: _____ Date: _____