



Group Marketing Services, Inc.

Group Insurance That Benefits Small Business

GROUP INSURANCE ENROLLMENT FORM

P.O. BOX 19040 • Kalamazoo MI 49019-0040 • Phone:(269)343-2611 • Fax:(269)349-3275
www.GroupMarketingServices.com • E-mail:EnrollmentGeneralMailbox@groupmarketingservices.com

Please complete EACH section of this application in ink. There can be NO whiteout on this application.

Section 1 - Employee Information (REQUIRED)

Employee's Last Name	First	M.I.	Date of Birth	Social Security Number	<input type="checkbox"/> Male <input type="checkbox"/> Female
Employer's Name:				Full Time Hire Date:	
Will you be Actively at Work <input type="checkbox"/> No when this coverage is to begin? <input type="checkbox"/> Yes: If "NO", Reason: _____ Return to work date: _____					
Hours Worked Per Week:	Do You Receive Commission Only Wages? <input type="checkbox"/> Yes <input type="checkbox"/> No	Occupation		Height ' "	Weight lbs
E-mail address:			Smoker: <input type="checkbox"/> No <input type="checkbox"/> Yes; packs per day: _____ years smoking: _____		
Mailing Address		City	State	Zip Code	Home Phone No. ()
Are you covered by other insurance: <input type="checkbox"/> No <input type="checkbox"/> Yes (including Medicare)				Type of Policy (Group, COBRA or Individual)	Date of Policy Start Date End Date
Policyholder Name & D.O.B.	Relationship	Name of Carrier			

Section 2 - Spouse Information (REQUIRED)

List spouse even if waiving spouse coverage

Marital Status: <input type="checkbox"/> Single; <input type="checkbox"/> Married, Date: _____ <input type="checkbox"/> Widowed, Date: _____ <input type="checkbox"/> Divorced, Date: _____ <input type="checkbox"/> Separated, Date: _____	Spouse's Full Legal Name		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Height ' "	Weight lbs
	Social Security Number	Smoker: <input type="checkbox"/> No <input type="checkbox"/> Yes; packs per day: _____ years smoking: _____		Employer: _____ <input type="checkbox"/> Unemployed		
Does your spouse reside at the same address: <input type="checkbox"/> No <input type="checkbox"/> Yes; Address(if different): _____						
Is your spouse covered by other insurance: <input type="checkbox"/> No <input type="checkbox"/> Yes (including Medicare)				Type of Policy (Group, COBRA or Individual)	Date of Policy Start Date End Date	
Policyholder Name & D.O.B.	Relationship	Name of Carrier				

Section 3 - Child(ren) Information (REQUIRED)

List all children under the age of 26 even if waiving child(ren) coverage

Child(ren)'s Full Legal Name First Last	Gender	Date of Birth (MM/DD/YY)	Relationship (son, daughter, stepchild)	Child(ren)'s Employment Status	
A.	<input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/> Part-Time <input type="checkbox"/> Full-Time <input type="checkbox"/> Unemployed Is child eligible for coverage through their employer: <input type="checkbox"/> Yes <input type="checkbox"/> No	
B.	<input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/> Part-Time <input type="checkbox"/> Full-Time <input type="checkbox"/> Unemployed Is child eligible for coverage through their employer: <input type="checkbox"/> Yes <input type="checkbox"/> No	
C.	<input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/> Part-Time <input type="checkbox"/> Full-Time <input type="checkbox"/> Unemployed Is child eligible for coverage through their employer: <input type="checkbox"/> Yes <input type="checkbox"/> No	
D.	<input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/> Part-Time <input type="checkbox"/> Full-Time <input type="checkbox"/> Unemployed Is child eligible for coverage through their employer: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are any of your child(ren) covered by other insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes (including Medicare)				Type of Policy (Group, COBRA or Individual)	Date of Policy Start Date End Date
Dependents Covered	Policyholder Name & D.O.B.	Relationship	Name of Carrier		

Section 4 – Health Information (REQUIRED)

Within the last five years, have you or your dependents been treated for, had any trouble with any of the following:

- | | | | | | | | | |
|---|-----------------------------|-------------------------------------|-----------------------------|-----------------------------|----------------------------|------------------------------------|-----------------------------|------------------------------|
| 1. ever been in a hospital as a patient? | <input type="checkbox"/> No | <input type="checkbox"/> Yes, whom; | <input type="checkbox"/> EE | <input type="checkbox"/> SP | <input type="checkbox"/> A | <input type="checkbox"/> B | <input type="checkbox"/> C | <input type="checkbox"/> D |
| 2. had any surgery or been advised to have surgery and have not done so yet? | <input type="checkbox"/> No | <input type="checkbox"/> Yes, whom; | <input type="checkbox"/> EE | <input type="checkbox"/> SP | <input type="checkbox"/> A | <input type="checkbox"/> B | <input type="checkbox"/> C | <input type="checkbox"/> D |
| 3. taken any prescription medication for more than 15 days? | <input type="checkbox"/> No | <input type="checkbox"/> Yes, whom; | <input type="checkbox"/> EE | <input type="checkbox"/> SP | <input type="checkbox"/> A | <input type="checkbox"/> B | <input type="checkbox"/> C | <input type="checkbox"/> D |
| 4. been consulted or treated for or had treatment recommended for excess user of alcohol or drugs? | <input type="checkbox"/> No | <input type="checkbox"/> Yes, whom; | <input type="checkbox"/> EE | <input type="checkbox"/> SP | <input type="checkbox"/> A | <input type="checkbox"/> B | <input type="checkbox"/> C | <input type="checkbox"/> D |
| 5. been consulted or treated for or had treatment recommended for nervous mental disorders? | <input type="checkbox"/> No | <input type="checkbox"/> Yes, whom; | <input type="checkbox"/> EE | <input type="checkbox"/> SP | <input type="checkbox"/> A | <input type="checkbox"/> B | <input type="checkbox"/> C | <input type="checkbox"/> D |
| 6. applied for or received disability income benefits or pension benefits on account of sickness or injury? | <input type="checkbox"/> No | <input type="checkbox"/> Yes, whom; | <input type="checkbox"/> EE | <input type="checkbox"/> SP | <input type="checkbox"/> A | <input type="checkbox"/> B | <input type="checkbox"/> C | <input type="checkbox"/> D |
| 7. aware of any condition, which may require ongoing or future treatment of any type? | <input type="checkbox"/> No | <input type="checkbox"/> Yes, whom; | <input type="checkbox"/> EE | <input type="checkbox"/> SP | <input type="checkbox"/> A | <input type="checkbox"/> B | <input type="checkbox"/> C | <input type="checkbox"/> D |
| 8. currently pregnant, disabled or hospital confined? | <input type="checkbox"/> No | <input type="checkbox"/> Yes, whom; | <input type="checkbox"/> EE | <input type="checkbox"/> SP | <input type="checkbox"/> A | <input type="checkbox"/> B | <input type="checkbox"/> C | <input type="checkbox"/> D |
| 9. have you or your dependents been treated for or had any trouble with any of the following: | | | | | | | | |
| a. Heart or chest pain? ... | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | | | h. Lungs disorders? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| b. High blood pressure? . | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | | | i. Arthritis or rheumatism? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| c. High cholesterol? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | | | j. Ulcers or stomach disorders? .. | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| d. Heart attack? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | | | k. Intestines or Kidneys? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| e. Abnormal pulse? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | | | l. Liver or gallstones? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| f. Cancer or tumors? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | | | m. Genital disorder? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| g. Diabetes? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | | | n. Urinary system? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| | | | | | | o. Goiter or glands? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| | | | | | | p. Pleurisy or asthma? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| | | | | | | q. Chronic diarrhea? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| | | | | | | r. Neuritis or sciatica? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| | | | | | | s. Back or spinal disorders? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| | | | | | | t. Sleeping disorders? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| | | | | | | u. Brain or head disorders? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

Questions #	Dependent	Thoroughly explain "Yes" answers. Include dates of services, current condition status, names and dosages of medications;

Section 5 – Coverage Election and Waiver Information (REQUIRED)

1) **Enrollment Type:** The reason why you are making application for coverage at this time.

Initial Enrollment: <input type="checkbox"/> Newly hired Employee	Open Enrollment: <input type="checkbox"/> Enrolling an Employee or Dependent, that has no other coverage, during your group's Open Enrollment month.
Special Enrollment (life event)	
<input type="checkbox"/> Involuntary Loss of Other Coverage. Date: _____ due to: <input type="checkbox"/> Termination of employment. <input type="checkbox"/> Legal separation, divorce or death of spouse. <input type="checkbox"/> Reduction in the number of hours of employment.	<input type="checkbox"/> Addition of a Dependent. Date: _____ due to: <input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Adoption/Placement for adoption

2) **Life Insurance Coverage:** Life coverage cannot be waived on Eligible Employees or Dependents, it requires 100% participation.

Primary Beneficiary: (Full Legal Name)	Relationship	Address (if different than employee's)

3) **Medical, Optical and Dental Insurance Coverage:** Your employer may offer some or all of these coverages. Make coverage elections below.

Employee Coverage: <input type="checkbox"/> Elect <input type="checkbox"/> Decline/Waive*	Spouse Coverage: <input type="checkbox"/> Elect <input type="checkbox"/> Decline/Waive*	Child(ren) Coverage: <input type="checkbox"/> Elect <input type="checkbox"/> Decline/Waive*
<i>* If declining/waiving any coverage above that you or your dependents are eligible for read and sign the below waiver statement</i>		
Waiver of Coverage Statement		
<p>If you decline / waive coverage for yourself or your dependents, there are only certain times in the future you may enroll yourself and/or your dependents in this plan.</p> <ul style="list-style-type: none"> If you or your dependents are declining enrollment because you have other creditable health insurance coverage, you may in the future enroll yourself and/or your dependents in this plan if the other coverage is terminated as a result of involuntary loss of eligibility. Enrollment must be made in writing and received at Group Marketing Services, Inc. within 30 days after your other coverage ends. "Loss of eligibility" includes loss of coverage due to legal separation, death, divorce, termination of employment or reduction in hours. It does not include a loss of coverage due to failure to pay premiums, termination for cause such as making a fraudulent claim or waiver of other coverage. If you decline coverage because you have COBRA continuation coverage under another plan, you must exhaust your COBRA coverage before you may enroll in this plan. You may in the future enroll yourself and/or your dependents in this plan, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption. Enrollment must be made in writing and received by Group Marketing Services within 30 days after the marriage, birth, adoption or placement for adoption. <p>You may in the future enroll yourself and/or your dependents in this plan during your group's Open Enrollment period only if and/or your dependents have no other health insurance coverage. Open Enrollment is a one month period four (4) months prior to your group's renewal date. Enrollment must be made in writing and received at Group Marketing Services, Inc. during the month of Open Enrollment.</p> <p>I hereby certify that the benefits provided under the group insurance made available to me by my Employer have been explained to me and that I have been given an opportunity to apply within 31 days of my eligibility period. I have elected to waive that opportunity. I voluntarily decline to participate in the group insurance Plan(s) selected above that I am otherwise eligible to participate in.</p>		
*Employee Signature (If waiving): _____		Date: _____

Section 6 – Statement of Understanding (REQUIRED)

By signing this application, I represent that all my answers are complete and accurate, and that I understand and agree to the following conditions:

- No independent producer, agent or employee of the insurer, or my employer can change any part of this application or waive the requirement that I answer all questions completely and accurately.
- The insurer may, at its discretion, request supplemental information from me, any family member listed on this application or any health care provider.
- On behalf of myself and all enrolled family members, I understand if the insurer discovers any intentional misrepresentation, omission or concealment of fact in obtaining coverage that was or would have been material to the insurer's acceptance of a risk, extension of coverage, provision of benefits or payment of any claim, the insurer may take action against me or my employer, including but not limited to increasing premiums.
- All dependents listed in the dependent section of this form are eligible as defined by the Plan (i.e. biological, adopted or step child) and agree to notify my employer promptly if and when there is a change in my dependent status.
- I authorize my employer to deduct the required contribution, if any, from my earnings.
- Faxed or copied applications are not considered application and are not accepted. Application must be complete and have an original signature.
- If this application is approved, coverage for myself and any eligible family members named on this application will begin on the date assigned by the insurer.
- Coverage is only in effect after receiving written approval from the insurance company.
- Applications for loss of coverage are effective the 1st of the month following receipt.
- Application MUST be received in our office within 30 days of a Special (i.e. marriage, birth, adoption or loss of coverage) or Timely Event (i.e. hire date) or coverage cannot be offered.
- Applications for Open Enrollment must be received during the month of Open Enrollment.
- Preexisting condition waiting period: There are no benefits available under this policy for services, supplies, drugs or other charges that are provided within 12 months after an insured's enrollment date for any preexisting condition. In certain circumstances, qualifying previous coverage will be credited towards the preexisting condition waiting period.
- My employer's master group policy is the document that sets forth all terms of my coverage, and no independent producer, agent of other person can change the terms of the master group policy, an of its amendments, or this application, except with an amendment issued expressly for that purpose and signed by an authorized office of the insurer.
- I understand this application will become part of the contract between the insurer and my employer.
- I affirm that I have reviewed all answers given on this application and, regardless of whether an independent producer or other person has filled out the answers for me, I verify that the answers are true and complete.
- Any person who knowingly, and with intent to injure, defraud or deceive any insurance company, files an insurance application containing any false, incomplete or misleading information is guilty of a criminal act punishable under law.

AUTHORIZATION for the release of information

To: (1) Any licensed physician, medical practitioner, hospital, clinic, or other medically related facility; (2) any insurance company or health maintenance organization (or similar type organization or institution); and (3) the Medical Information Bureau. I authorize you to give any data, information or records you may have about me or my mental or physical health to Assurity Life Insurance Company or Group Marketing Services, Inc or its subsidiaries. This authorization includes information related to all conditions, treatments and diagnoses including, but not limited to: HIV/AIDS, alcohol and drug use, mental/nervous conditions. This authorization also applies to any dependent applying for coverage on this application. A photocopy of this form will be as valid as the original.

Employee/Applicant's Signature: _____ Date: _____

Spouse/Applicant's Signature (if applicable): _____ Date: _____

Section 7 – Employer Approval (REQUIRED)

Company Name		<input type="checkbox"/> Management <input type="checkbox"/> Non-Management	<input type="checkbox"/> Hourly <input type="checkbox"/> Salaried	<input type="checkbox"/> Union <input type="checkbox"/> Non-Union	Commissioned Only? <input type="checkbox"/> Yes <input type="checkbox"/> No	Base Salary Plus Commission? <input type="checkbox"/> Yes <input type="checkbox"/> No
Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Contracted			Earnings: \$ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Semi-Monthly			
Full Time Hire Date	Lay-Off Date	Leave of Absence Date	Reduction in Hours Date	Termination Date	Return to Work Date	Re-Hire Date

Approval Signature: _____ Date: _____