

# Group Marketing Services, Inc.

P.O. BOX 19040 • Kalamazoo MI 49019-0040 • (269)343-2611

## GROUP INSURANCE ADDITION OF NEWBORN ENROLLMENT FORM

### SECTION 1 – EMPLOYEE INFORMATION (REQUIRED)

Employee Last Name	First	M.I.	Date of Birth	Social Security Number	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Marital Status: <input type="checkbox"/> Single <sup>^</sup> ; <input type="checkbox"/> Married, Date: _____ <input type="checkbox"/> Widowed, Date: _____ <input type="checkbox"/> Divorced <sup>^</sup> , Date: _____ <input type="checkbox"/> Separated <sup>^</sup> , Date: _____					
<sup>^</sup> if marital status is single, divorced or separated when adding a newborn, proof of support is required with enrollment. Proof of support consists of 1) court order; or 2) affidavit of parentage; or 3) birth certificate listing both parents' names.					
Are you currently Working: <input type="checkbox"/> Yes <input type="checkbox"/> No, Reason: _____ Return to work date: _____					
Hours Worked Per Week:	Do You Receive Commission Only Income? <input type="checkbox"/> Yes <input type="checkbox"/> No		Enrollment Type: <input checked="" type="checkbox"/> <b>Special</b> Addition of Dependent due to Birth		
If additional information is needed for this enrollment contact: <input type="checkbox"/> Do not contact me, contact my employer <input type="checkbox"/> Me at Home Phone Indicated Below <input type="checkbox"/> Me at e-mail address: _____ <input type="checkbox"/> Me at Phone No: (_____) _____					
Physical Home Street Address	Apt. No.	City	State	Zip Code	Home Phone No. (_____) _____
Primary Beneficiary (Full Legal Name)		Relationship	Address (if different than employee's)		

### SECTION 2 – NEWBORN INFORMATION (REQUIRED)

Child(ren)'s Full Legal Name First M.I. Last	Date of Birth (MM/DD/YY)	Relationship	Dependent Social Security Number Dependent Address (if different then Employee)
A.		<input type="checkbox"/> Son <input type="checkbox"/> Daughter	S.S. #: _____
B.		<input type="checkbox"/> Son <input type="checkbox"/> Daughter	S.S. #: _____
C.		<input type="checkbox"/> Son <input type="checkbox"/> Daughter	S.S. #: _____

Does the newborn(s) have any condition, illness or injury which may require ongoing or future surgery or treatment of any type, or has any surgery or treatment been recommended that has not yet been performed? .....  No  Yes, whom \_\_\_\_\_ Which above Child(ren):  A  B  C

Thoroughly explain "Yes" Answer; \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### SECTION 3 – COVERAGE ELECTION INFORMATION (REQUIRED)

**Life Insurance:** Requires 100% / No Waivers **Medical / Dental\* / Optical\* Insurance:**  Yes  No \* Some coverages indicated may not be offered

### SECTION 4 – OTHER COVERAGE INFORMATION (IF APPLICABLE)

Is the newborn(s) covered by other Insurance coverage on or after the effective date of this plan?  Yes  No

Other Coverage Type: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Rx <input type="checkbox"/> Optical <input type="checkbox"/> Other:	Insurance Company Name & Phone Number	Policy Number	Name of Policyholder
	Policyholder & D.O.B.:	Coverage Effective Date:	

### SECTION 5 – SIGNATURE INFORMATION (REQUIRED)

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|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ol style="list-style-type: none"> <li>I hereby certify that 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.</li> <li>I hereby request the Insurance I have elected, and may become eligible for, and hereby authorize my employer to deduct the required contribution, if any, from my earnings.</li> <li>Coverage is only in effect after receiving written approval from the insurance company.</li> </ol> | <ol style="list-style-type: none"> <li>Faxed or copied applications are not considered application and are not accepted. Application must be complete and have an original signature.</li> <li>Applications for loss of coverage are effective the 1<sup>st</sup> of the month following receipt.</li> <li>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.</li> <li>Applications for Open Enrollment must be received during the month of Open Enrollment.</li> </ol> |
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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. I hereby agree to reimburse Assurity Life Insurance Company (Assurity) to the extent of any overpayment which is in excess of the amounts payable under any Assurity insurance policy(ies). I hereby certify the statements above are complete and accurate to the best of my knowledge.

Employee/Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**SECTION 6 – FOR EMPLOYER USE ONLY (REQUIRED)**

Company Name		<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	
Earnings: \$		<input type="checkbox"/> Full Time	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Semi-Monthly	<input type="checkbox"/> Annually	<input type="checkbox"/> 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
Employment Status: <input type="checkbox"/> Full Time		<input type="checkbox"/> Part Time	<input type="checkbox"/> Seasonal	<input type="checkbox"/> Contracted	<input type="checkbox"/> Board Member	<input type="checkbox"/> Temporary

Approval Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**SECTION 7 – WAIVER OF COVERAGE (IF APPLICABLE)**

- I / My Dependent(s) have other group health plan coverage or other health insurance coverage. I / My Dependent(s) understand I will only be given an opportunity again for Timely Enrollment if I apply within 30 days of losing my other group health plan coverage or other health insurance coverage or if I apply within 30 days of acquiring a new dependent either by marriage, birth or adoption as described below in "Special Enrollment". **Please Describe Other Coverage(s) in Section 4 above.**
- I / My Dependent(s) have no other coverage. I understand I will only be given an opportunity again for Timely Enrollment if I apply properly within 30 days of acquiring new dependent(s) either by marriage, birth or adoption.
- "Timely Entrant" and "Timely Enrollment" means an Employee of Dependent who applies for insurance within 31 days of first becoming eligible. A person who enrolls during a Special Enrollment Period is a Timely Entrant.

**SPECIAL ENROLLMENT**

If you decline enrollment for yourself or your dependents because of other 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, provided you request enrollment in writing by completing form GP2917 and it is 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 or termination for cause such as making a fraudulent claim.
- You have a new dependent as a result of marriage, birth, adoption or placement for adoption, provided you request enrollment in writing on form GP2917 and the original completed enrollment is received by Group Marketing Services within 30 days after the marriage, birth, adoption or placement for adoption. The coverage will be gin on the date of marriage, birth, or placement for adoption. Facsimiles are not considered original or properly completed, acceptable enrollment.

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.

**Please mark coverage you are waiving:**

Employee Health/Dental/Optical       Dependent Spouse Health/Dental/Optical       Dependent Child(ren) Health/Dental/Optical

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 below that I am otherwise eligible to participate in.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

<b>For Insurance Company Use Only</b>	Effective Date:	Insured No.:	Policy No.: