Group Marketing Services, Inc.

Group Insurance That Benefits Small Business

INSURANCE ENROLLMENT FORM

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

Section 1 – Employee Information (ALL FIELDS ARE REQUIRED)

Employee's Last Name	First	M.I.	Date of Birth	Social Security Number (Required)	☐Male ☐Female

Employer's Name:	Hire Date	Height ' "	Weight lbs

Occupation:	Hours Worked Per Week:	Do You Receive Commission Only Wages? ☐No ☐Yes

E-mail address: | Tobacco: ☐No ☐Yes; Type: amount per day: years:

Marital Status: ☐Single; ☐Married, , Date: ☐Widowed, Date: ☐Divorced, Date: ☐Separated, Date:

Mailing Address	City	State	Zip Code	Home Phone No. ( )

Other than through your employer, are you covered by any other insurance? ☐No ☐Yes (including MEDICARE)

Policyholder Name & D.O.B.	Relationship to EE	Name of Insurance Carrier	Effective Date	Type of Policy (Group, COBRA or Individual)

Section 2 – Spouse Information - Complete This Section Even If Waiving Spouse Coverage

Spouse's Full Legal Name	Date of Birth	☐Male ☐Female	Date of Marriage	Height ' "	Weight lbs

Social Security No. (REQUIRED): | Tobacco: ☐No ☐Yes; Type: amount per day: years:

Spouse's Employment ☐Part-Time ☐Full-Time ☐Unemployed	Employer	Occupation:

Do you and your spouse reside at the same address: ☐No ☐Yes; Address(if different):

Other than through your employer, is your spouse covered by any other insurance? ☐No ☐Yes (including MEDICARE)

Policyholder Name & D.O.B.	Relationship	Name of Carrier	Effective Date	Type of Policy (Group, COBRA or Individual)

Section 3 – Child(ren) Information (REQUIRED if your children are under 26)

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

Do you have any children (step or biological under the age of 26? ☐No ☐Yes If Yes, all children must be listed in section 3

Child(ren)'s Full Legal Name First Last	Gender	Date of Birth (MM/DD/YY)	Relationship (son, daughter, stepchild)	Child(ren)'s Social Security Number
A.	☐Male ☐Female			
B.	☐Male ☐Female			
C.	☐Male ☐Female			
D.	☐Male ☐Female			
E.	☐Male ☐Female			

Other than through your employer, is your child(ren) covered by any other insurance? ☐No ☐Yes (including MEDICARE)

Dependents Covered	Policyholder Name & D.O.B.	Relationship	Name of Carrier	Effective Date	Type of Policy (Group, COBRA or Individual)
☐A ☐B ☐C ☐D ☐E					
☐A ☐B ☐C ☐D ☐E					
☐A ☐B ☐C ☐D ☐E					

Section 4 – Health Information (REQUIRED)

WITHIN THE LAST FIVE YEARS, HAVE YOU OR YOUR DEPENDENTS:

1. been admitted to a hospital as a patient? ☐No ☐Yes, whom; ☐EE ☐SP ☐A ☐B ☐C ☐D ☐E

Reason:	Current Status:	admission date	discharge date:

2. had any surgery? ☐No ☐Yes, whom; ☐EE ☐SP ☐A ☐B ☐C ☐D ☐E

Condition:	Procedure:	Current Status:	Surgery date:

3. been advised to have surgery, but have not done so yet? ☐No ☐Yes, whom; ☐EE ☐SP ☐A ☐B ☐C ☐D ☐E

Condition:	Recommended Procedure:	Prognosis:

4. taken any prescription medication for more than 15 days? ☐No ☐Yes

Who	Medication:	Strength:	Dosage:	Date last taken:	Condition treated:

5. currently pregnant? ☐No ☐Yes, whom; ☐EE ☐SP ☐A ☐B ☐C ☐D ☐E

Due Date:	Delivery Type?	First Child?	Prognosis or known issues:
	☐Vaginal ☐Cesarean	☐No ☐Yes	

6. applied or received SSDI, STD, LTD or pension benefits because of sickness or injury? ☐No ☐Yes, whom; ☐EE ☐SP ☐A ☐B ☐C ☐D ☐E

Condition:	Policy Type	Total amount collected:	Current Status	Dates:
		$		

7. currently disabled or hospital confined? ☐No ☐Yes, whom; ☐EE ☐SP ☐A ☐B ☐C ☐D ☐E

Condition:	Treatment / Location:	Current Status or Discharge Date:

8. been treated for or had any trouble with any of the following: ☐No ☐Yes

a. Heart attack or stroke? ☐No ☐Yes
b. Heart or chest pain? ☐No ☐Yes
c. Other heart condition? ☐No ☐Yes
d. High blood pressure? ☐No ☐Yes
e. High cholesterol? ☐No ☐Yes
f. Hypertension? ☐No ☐Yes
g. Diabetes? ☐No ☐Yes
h. Cancer or tumor? ☐No ☐Yes
i. COPD or Asthma? ☐No ☐Yes
j. Other Lung disorder? ☐No ☐Yes
k. Arthritis or rheumatism? ☐No ☐Yes
l. Ulcers or stomach disorder? ☐No ☐Yes
m. Intestine or bowel disorder? ☐No ☐Yes
n. Liver or gallstones? ☐No ☐Yes
o. Urinary system or Kidneys? ☐No ☐Yes
p. Goiter or glands? ☐No ☐Yes
q. Genital disorder? ☐No ☐Yes
r. Neuritis or sciatica? ☐No ☐Yes
s. Back or spinal disorder? ☐No ☐Yes
t. Brain or head disorder? ☐No ☐Yes
u. Sleeping disorder? ☐No ☐Yes
v. Depression or Anxiety? ☐No ☐Yes
w. Other mental health disorder? ☐No ☐Yes
x. Substance use disorder? ☐No ☐Yes

Who?	Condition (a-x):	Treatment:	Current Status:

9. aware of any condition, not listed, that requires ongoing and/or future treatment? ☐No ☐Yes, whom; ☐EE ☐SP ☐A ☐B ☐C ☐D ☐E

Condition:	Treatment:	Current Status:

Section 5 – Designations and Elections (REQUIRED)

Enrollment Type: The reason you are making application for coverage at this time.

INITIAL ENROLLMENT* *(usually after completing a new hire waiting period)* **original form MUST be received within 30 days of the date coverage is to begin.*	OPEN ENROLLMENT* *(four months prior to group's renewal date)* **original form MUST be received DURING the month of Open Enrollment.*
☐ Newly hired employee ☐ Re-hired employee ☐ Returning to work from layoff, a leave of absence or reduction in hours	☐ Open Enrollment. I understand that anyone enrolling during Open Enrollment cannot have any other coverage during the Open Enrollment month and the waiting period is the first of the month following 30 days after receipt of a completed application.

SPECIAL ENROLLMENT *(original form MUST be received within 30 days of the date of the event or loss of coverage)*

INVOLUNTARY LOSS OF OTHER COVERAGE

Date coverage terminates:_____*(select one of the following)*

- ☐ Termination of employment
- ☐ Reduction in the number of hours of employment
- ☐ Legal separation or divorce
- ☐ Death of spouse
- ☐ Dependent ceasing to be an eligible dependent (age 26)

ADDITION OF A DEPENDENT

Date of event::_____*(select one of the following)*

- ☐ Marriage
- ☐ Birth
- ☐ Adoption
- ☐ Placement for adoption

COVERAGE ELECTIONS

LIFE AND DISABILITY COVERAGE: (If offered by your employer) life and disability coverages are mandatory for all eligible employees. Life coverage is also mandatory for all dependents. These coverages cannot be waived. By completing and submitting this application you and your dependents (listed in sections 2 & 3 of this form) will be enrolled in these coverage (if offered by your employer).

Employee Coverage (select one)		Spouse Coverage (select one)	
Disability (if offered):	mandatory coverage (no waivers allowed)	☐Not Married ☐Spouse is not eligible (divorced or separated)	
Life (if offered):	mandatory coverage (no waivers allowed)	**Life** (if offered):	Mandatory coverage (no waivers allowed)
Medical (if offered):	☐Elect ☐Waive/Decline	**Medical** (if offered):	☐Elect ☐Waive/Decline
Dental (if offered):	Same as Medical election, benefit packaged	**Dental** (if offered):	Same as Medical election, benefit packaged
Vision (if offered):	Same as Medical election, benefit packaged	**Vision** (if offered):	Same as Medical election, benefit packaged

Child(ren) Coverage

☐I have no Children under the age of 26 ☐My children under age 26 are not eligible for coverage

Life (if offered): Mandatory Coverage, no waivers allowed.

Medical (if offered): ☐Elect All Children ☐Elect Only Certain Child(ren):_____

☐Waive All Children ☐Waive Only Certain (Children):_____

Dental (if offered): Same as Medical election, benefits are packaged.

Vision (if offered): Same as Medical election, benefits are packaged.

Future Enrollment Opportunities: If you are declining/waiving any coverage you or your dependents are eligible for during your initial enrollment period, PLEASE NOTE: there are only certain times in the future this plan allows you an opportunity to enroll. The following are enrollment periods allowed by this plan:

- Open Enrollment (annually): a one (1) month enrollment period, beginning four (4) months prior to your group's renewal date. To enroll during Open Enrollment you may not have any other health insurance coverage, proper written application must be received during the month of Open Enrollment and you must have submitted a proper written waiver when you were first eligible to enroll (i.e. Initial Enrollment).
- Special Enrollment (enrollment triggered by an event):
  - New Dependent: If you acquire a new dependent as a result of marriage, birth, adoption or placement for adoption you may enroll yourself and/or your new dependent in this plan within 30 days of the event.
  - Involuntary Loss of Coverage: If you originally decline/waive health coverage because you or your dependents have other coverage, you may in the future enroll in this plan if there is an involuntary loss of coverage. Some examples of an involuntary loss of coverage are a 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, waiver of coverage or termination for cause such as making a fraudulent claim. 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. To enroll, proper written application must be received within 30 days of the loss of coverage date and you must have submitted a proper written waiver when you were first eligible to enroll (i.e. Initial Enrollment).

LIFE INSURANCE BENEFICIARY DESIGNATION (Required): Designate who you would like to receive your life insurance benefit in case of your death. The employee is always the beneficiary for the dependent life insurance benefit (i.e. spouse and children).

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

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 or 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 sections 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 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 you and any eligible family members named on this application will begin on the date assigned by the insurance company.
- Coverage is only in effect after receiving written approval from the insurance company.
- Preexisting condition waiting period: Except for child(ren) under the age of 19, 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, or 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	☐Management ☐Non-Management	☐Hourly ☐Salaried	☐Union ☐Non-Union	Commissioned Only? ☐Yes ☐No	Base Salary Plus Commission? ☐Yes ☐No
Employment Status: ☐Full Time ☐Part Time ☐Seasonal ☐Contracted		Earnings: $		☐Hourly ☐Weekly ☐Bi-Weekly ☐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:_____