☐ New Enrollee ☐ Coverage Change ☐ Waiver (See Section 6)
☐ COBRA/MSE Enrollee ☐ Information Update

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EMPLOYEE ELECTION FORM

Every Item Must Be Completed (This is not an application for insurance)

1. EMPLOYEE INFORMATION (Your employer will complete the shaded boxes in this section)

Last Name	First Name	M.I.	Social Security Number	Employer Section
			- -	Effective Date(s): Medical:_____ Life/STD:_____ Dental:_____ LTD:_____ Vision:_____
Street Address			Date of Hire	
City	State	Zip Code	Hours Worked Per Week	GBS Account Number

Sex ☐ Male ☐ Female	Date of Birth	Home Phone #	Business Phone # Extension	Annual Salary	Effective Date

Marital Status ☐ Single ☐ Divorced ☐ Domestic Partner ☐ Married ☐ Widowed	Date of Marriage	Name of Employer	Benefit Class/Occupation

2. GENERAL INFORMATION (Complete entire line for all listed)

	Last Name First Name M.I.	Date of Birth	Social Security #	Sex	IF HMO OR POS PLAN: Primary Care Provider #	Current Patient (Y/N)	Dentist Code	Medical (Y/N)	Dental (Y/N)	Vision (Y/N)	Debit Card (Y/N)
Self											
Sp/DP			- -								
Child			- -								
Child			- -								
Child			- -								

Are any of your dependents Disabled (Y/N) _____ or Full-Time Student (Y/N) _____ If so, name of dependent _____

3. OTHER HEALTH/DENTAL INSURANCE INFORMATION (You must complete this section or claims may be denied)

Do you or your dependents described on this form have "health" or "dental" coverage with another insurer? ☐ Yes ☐ No Effective Date: _____ Term. Date: _____
Who is covered? ☐ Self ☐ Spouse ☐ All Other Carrier Name: _____ Policy # _____
Will you or your dependents continue coverage with other insurer? ☐ Yes ☐ No Other coverage is through ☐ Individual Policy ☐ Spouse's Employer
Are you covered by **Medicare**: ☐ No ☐ Yes Effective Date (Part A) _____/_____/_____ (Part B) _____/_____/_____ Medicare # _____
Are any of your dependents covered by **Medicare**: ☐ No ☐ Yes Effective Date (Part A) _____/_____/_____ (Part B) _____/_____/_____ Medicare # _____

4. BENEFIT ELECTION (Indicate level of coverage elected for each benefit offered by your employer)

MEDICAL PLAN	DENTAL PLAN	VISION PLAN	LIFE INSURANCE	SHORT TERM DISABILITY	LONG TERM DISABILITY	GBS ADVANTAGE HRA
Carrier: _____	Carrier: _____	Carrier: _____	Carrier: _____	Carrier: _____	Carrier: _____	Carrier: _____
Plan: _____	Plan: _____	Plan: _____	Plan: _____	Plan: _____	Plan: _____	Plan: _____
Group# _____	Group# _____	Group# _____	Group# _____	Group# _____	Group# _____	Group# _____
☐ Individual	☐ Individual	☐ Individual	☐ Life Insurance/AD&D	☐ Short Term Disability	☐ Long Term Disability	☐ Individual
☐ Individual & 1 Child	☐ Individual & 1 Child	☐ Individual & 1 Child	☐ Supplemental Life Benefit: _____	☐ Voluntary STD Benefit:_____	☐ Voluntary LTD	☐ Individual & 1 Child
☐ Individual & Adult	☐ Individual & Adult	☐ Individual & Adult	☐ Dependent Life	☐ NONE	☐ NONE	☐ Individual & Adult
☐ Individual & Children	☐ Individual & Children	☐ Individual & Children	☐ NONE			☐ Individual & Children
☐ Family	☐ Family	☐ Family				☐ Family
☐ Comp. to Medicare (Ind. Only and Benefit Coverage Only, Not Eligible for HSA.)	☐ NONE	☐ NONE				☐ NONE
☐ NONE						

5. LIFE INSURANCE BENEFICIARY:

Beneficiary Name	Relationship	%

Important - Special Carrier Information/Waiver Information Below - Please Read and Check All That Apply

❑ **GBS Advantage HRA**

I understand that my elections are binding for the entire Plan Year and cannot be revoked, modified or amended unless due to a limited family status change. Under penalty of perjury I agree to use the debit card solely for the purchase of eligible expenses not covered by any other plan. I am responsible for providing proof to support reimbursed expenses and agree that any reimbursed expenses later discovered to be ineligible may be deducted from my paycheck by my employer. I authorize the release of claims information to my employer and Group Benefit Services, Inc.

6. WAIVER

I hereby certify that the benefits provided by my Employer have been explained to me, that I have been given an opportunity to elect coverage and that I voluntarily decline to participate in the benefits checked "NONE" at this time. I understand that I may be required to wait until the next open enrollment period (if applicable) or until a Special Enrollment event for medical or dental coverage, or be required to provide evidence of insurability for life or disability benefits.

Reason for Waiver: ☐ Coverage Elsewhere Carrier Name: _____ ☐ Not Interested

CERTIFICATION: I hereby enroll, on behalf of myself and each dependent listed above, for the coverage indicated. If this Form is accepted, coverage will be provided according to terms and conditions of the contract between the carrier and my employer. I agree to pay current and future charges for the coverage provided in excess of any employer contribution.
Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
I have carefully read this Form and agree to its terms. The recorded answers on this Form are, to the best of my knowledge and belief, full, complete and true as of this date. I certify that I am the spouse, parent, legal guardian (or the dependent has been placed in my home for adoption) of the dependents listed above and they are dependent upon me for primary support as defined by the IRS.
If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a membership services representative before signing this enrollment card.

EMPLOYEE SIGNATURE: _____ **DATE:** _____

EMPLOYER SIGNATURE/VERIFICATION: _____ **DATE:** _____