

Employee Enrollment Form

Administered By: GETTYSBURG HEALTH ADMINISTRATORS
404 Baltimore Street, P.O. Box 1060 Gettysburg, PA 17325-1060

- Delta Dental of PA
 VSP

- New Enrollment
 Add Dependent

* Please return all copies intact.

SHADED AREA FOR OFFICE USE ONLY	GROUP #:	EFFECTIVE DATE:	PROCESSED BY:	DATE:
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Employee Name: _____ Phone: _____

Full Address: _____

Date of Full-Time Employment: ____/____/____

	SEX	DATE OF BIRTH	SOCIAL SECURITY
	M/F		
INFORMATION ON EMPLOYEE TO BE INSURED:			
DEPENDENTS TO BE INSURED: (last name if different)	RELATIONSHIP		
1)			
2)			
3)			
4)			

Employer: _____ Are you covered by Workers' Compensation: Yes No
Job Title/Duties: _____ Insurance Class: _____

Are you working your regular work week with this employer: Yes: Weekly Hours: _____ Earnings: \$ _____ Annual Weekly Hourly
 No - Reason: COBRA Retired Disabled Other _____

Marital Status: Single Married Widowed Divorced Legally Separated

Complete if your spouse or dependents have other insurance.

	other dental carrier plan	Other Vision plan
Spouse:		
Dependents:		

If Applicable: Spouse's Employer: _____ Work Phone #: (____) _____

• To Request Coverages (Please read and sign below.)

I am requesting the coverage(s) selected above under the group policy(ies) issued by the insurer. I authorize any licensed physician, medical practitioner, hospital, medically related facility, utilization management or peer review organization, or any insurance company institution or person having any records or knowledge of myself, my health, and/or my dependents and their health to give such information to the insurer, its reinsurers or their representatives. A photocopy of this authorization shall be as valid as the original.

Conditions of Enrollment - I represent that all information supplied on this form is true and complete to the best of my knowledge and belief. I acknowledge and agree to the Conditions of Enrollment and the Consumer Notice(s) on the reverse side of this application.

Employer's Initials _____ **Employee's Signature** _____ **Date** ____/____/____

• To Decline Coverages (Please read and sign below.)

I understand that I am eligible for benefits under the group health insurance plan(s) for employees of the employer named above. Benefits under such plan(s) have been explained to me in detail. After careful consideration, I decline coverage(s) not selected above for myself and/or my eligible dependents and waive all claims to benefits under any of the plan(s).

Reason: Election of HMO coverage provided by my employer Coverage through my spouse's employer
 Declined for contributory benefits (employee pays portion of premium) Other reason _____

I hereby acknowledge the Health Insurance Portability & Accountability Act (HIPAA) Notice on the reverse side of this application.

Employer's Initials _____ **Employee's Signature** _____ **Date** ____/____/____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents,

CONSUMER NOTICE

If any investigation is conducted in connection with your application, you are entitled, under the Federal Fair Credit Reporting Act, to disclosure of the nature and scope of that investigation. If a consumer investigative report is prepared, you may obtain a copy of such report. Further information regarding the investigation and any investigative consumer reports may be obtained by mailing your request to:

The type of information the insurer may obtain includes any which relates to your mental and physical health, character and general reputation, habits, finances, occupation, income, insurance coverage, and participation in aviation and other hazardous activities.

If insurance is sought for members of your family, similar information may be requested about them. The insurer may also obtain information from your friends, neighbors, associates and past and present employers, either directly or through an investigative consumer report. Information obtained by an insurance-support organization

 **Gettysburg Health**
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