

Employee Enrollment Application

Administered By: Gettysburg Health Administrators, Inc.
34 Locust Ave, P.O. Box 1060 Gettysburg, PA 17325-1060

VSP vision

New Enrollment

Add Dependent

Delta Dental (2-9 only; for 10+ use SBA forms)

Name of Employer:

Please complete *each* section of this application in ink.

Shaded Area For Office Use Only	Group #:	Eff. Date:	Processed by:	Date:
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Applicant Information (Employee)					
Your Name (last, first, initial):					Social Security Number: - -
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (mm/dd/yy): / /	Date of Full-Time Employment: / /	Weekly Hours: _____/per week	Are you working your regular work week with this employer? <input type="checkbox"/> Yes <input type="checkbox"/> No - Reason: <input type="checkbox"/> COBRA <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Other	
Home Address (Street or Route):			City, State, Zip Code:		
Phone Number::	Email Address:		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated		
Are you covered by Workers' Compensation: <input type="checkbox"/> Yes <input type="checkbox"/> No	Job Title/Duties:		Insurance Class:		

Family Member Information (If you choose not to enroll all your eligible family members, you must complete a waiver form)						
<i>List all family members you wish to enroll, including any child who is under age 26; or who is medically certified as disabled and dependent on parent for support (copy of certification required).</i>						
	Status	Gender	Date of Birth (mm/dd/yy)	Social Security #	Height (ft-in)	Weight (lbs)
Applicant/Employee	SELF					
Family Member's Name (last if different than employee, first, initial)						
	<input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F	/ /			
Family Member's Name (last if different than employee, first, initial)						
	<input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F	/ /			
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	<input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F	/ /			
Family Member's Name (last if different than employee, first, initial)						
	<input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F	/ /			

34 Locust Ave. • Gettysburg, PA 17325 • (800) 497-4474

Mailing Address: P.O. Box 1060 • Gettysburg, PA 17325

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Type of Enrollment										
	Dental Coverage <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child/Children	Vision Coverage <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child/Children								
Coordination of Benefits										
Do you or any of your family members have other medical and/or dental coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO Coordinating your insurance benefits could reduce the amount you owe a provider. <i>(Please use extra paper if necessary.)</i>										
			Other Dental Insurance Carrier Plan Name: <input type="checkbox"/> Self _____ <input type="checkbox"/> Spouse _____ <input type="checkbox"/> Child/Children _____							
If any person listed on this application is covered by Medicare, please complete the following:										
<table style="width: 100%; border: none;"> <tr> <td style="border: none;">Name _____</td> <td style="border: none;">Medicare Beneficiary Number _____</td> <td style="border: none;">Reason for Medicare Entitlement (age, disability or ESRD) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none; text-align: center;"> Part A _____ / _____ / _____ mm dd yy </td> <td style="border: none; text-align: center;"> Part B _____ / _____ / _____ mm dd yy </td> </tr> </table>					Name _____	Medicare Beneficiary Number _____	Reason for Medicare Entitlement (age, disability or ESRD) _____		Part A _____ / _____ / _____ mm dd yy	Part B _____ / _____ / _____ mm dd yy
Name _____	Medicare Beneficiary Number _____	Reason for Medicare Entitlement (age, disability or ESRD) _____								
	Part A _____ / _____ / _____ mm dd yy	Part B _____ / _____ / _____ mm dd yy								
<i>If you have had other coverage with another carrier within 63 days (excluding any employee's probationary period) of this request, please attach a copy of your Certificate of Creditable Coverage if applicable, which can be obtained from your current or prior carrier; this will ensure proper credit for any preexisting conditions.</i>										
To Add Dependent Please Provide Qualifying Event Information										
Change current enrollment because of the following event: <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Birth <input type="checkbox"/> Involuntary loss of coverage <input type="checkbox"/> Death <input type="checkbox"/> Court order (copy of court order required) <input type="checkbox"/> Other _____ Date event occurred: _____ / _____ / _____ mm dd yy										
Disability Information										
Are you or any of your dependents currently disabled? <input type="checkbox"/> YES <input type="checkbox"/> NO										
Name of Disabled Person _____		Nature of Disability _____								
Date of Disability _____		Physician's Name _____		Physician's Phone Number _____						
Physician's Address _____										

To Request Coverages

(Please read and sign the below **statement of understanding**):

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

- I agree to abide by all of the terms and conditions of the group policy.
- If I decline to enroll any eligible family member on this application or a newly-eligible family member at a later date, I must complete, sign, and return to the insurer the Employee's Waiver of Health Care Coverage area of this form (located below).
- No independent producer, agent or employee of the insurer or of 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, or any fraudulent misstatements or activity, the insurer may take action against my employer, including but not limited to increasing premiums or retroactive cancellation of coverage.
- 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.
- I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law. I understand that upon written request I may revoke this authorization except to the extent that action has already been taken in reliance on this authorization. This authorization expires when coverage terminates. I understand that a facsimile or photocopy of this form is as valid as the original, and that I have a right to receive a copy of this form upon request.
- As proof of status of employment, I authorize my employer to release to the insurer appropriate documents, including but not limited to, W-2 Wage and Tax Statements and other wage and tax summaries or forms.
- For individuals over the age of 19, Preexisting condition waiting period: There is a \$2,000 limit available under this policy for services, supplies, drugs or other charges that are provided within 12 months. The twelve month period begins on the first day of coverage, or if there is a waiting period, on the first day of the waiting period.
- A preexisting condition is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the 90 days immediately preceding the enrollment date.

A pregnancy existing on the enrollment date is not a preexisting condition under this policy. Genetic information shall not be considered as a preexisting condition in the absence of a diagnosis of the condition related to such information. In certain circumstances, qualifying previous coverage may be credited toward the preexisting condition waiting period.

- If you have had group or individual health coverage or a government health care program for at least 12 months, you are entitled to receive a Certificate of Creditable Coverage from your previous employer or insurance company. This document will state the effective date of prior coverage and the termination date of coverage for you and any covered dependents. Your previous employer or insurance company will furnish you this certificate upon request. The insurer will assist in obtaining a certificate from a prior plan or insurance company if necessary. For additional information or assistance regarding preexisting condition exclusion please contact: 800.497.4474 or GettHealth, PO Box 1060, Gettysburg, PA 17325.
- I understand that it is my responsibility to report to my employer any changes in the eligibility of me or the individuals listed or any change to the information provided on this application.
- I authorize my employer to deduct any required contribution for the insurance coverage from my earnings.
- The master group policy, issued in conjunction with the master group application, is the document that sets forth all terms of my coverage, and no independent producer, agent or other person can change the terms of the master group policy, any of its amendments, or this application, except with an amendment issued expressly for that purpose and signed by an authorized officer of the insurer.
- Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties and may result in termination of benefits.
- I agree that a facsimile or photocopy of my signature will serve the same as an original.
- I understand that 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.**

X

Applicant's Signature

Date

Employee's Waiver of Health Care Coverage
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 for waiving coverage:

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

X

Applicant'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, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.