

INSURANCE DESIGN ADMINISTRATORS ENROLLMENT APPLICATION

SECTION 1

Your Last Name _____ First _____ M.I. _____ Your SS No. _____
 Single Married Divorced
 Address _____ In case of change due to Marriage: _____ In case of change due to Divorce: _____
 Date of Marriage ____/____/____ Date of Divorce ____/____/____
 Phone No. (____) _____ (____) _____
 City _____ State _____ Zip Code _____
 Employment Status: Active: Full-time Part-time Retired COBRA
 Date of Employment: ____/____/____ Date of Retirement: ____/____/____

Employer Use Only

Group Name _____
 Township of Wayne _____
 Group ID _____ Employee Code _____
 Effective Date Requested ____/____/____
 Network _____ Division _____
 Employer's Signature & Date _____

SECTION 2

| <input type="checkbox"/> New Enrollment/Reinstatement (complete Section 4) <input type="checkbox"/> Change Coverage to: (check new coverage) <input type="checkbox"/> Cancel Coverage: (check those that apply) <input type="checkbox"/> Add or Delete Dependent: (complete Section 4) <input type="checkbox"/> Change Enrollee's Information: (complete Section 1 with new information) REASON: _____ Date of change: ____/____/____ | Type | Option | Single | Husband/Wife or Parent/Child | Parent/Children or Family | Complement to Medicare |
|---|---------|-----------|--------------------------|------------------------------|---------------------------|--------------------------|
| | Medical | Plan A | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Medical | Plan C | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Medical | Plan D | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Medical | Plan E | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Medical | Plan F | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Dental | \$750 - D | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Dental | Rx Copay | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

SECTION 3

OTHER COVERAGE? (Inaccurate information may result in claim delay or denial.)
 Is there coverage under any other group health plan available to you or any member of your family?
 No Yes, Effective Date ____/____/____
 If Yes; Policyholder Name & ID/SS No. _____ Relationship _____
 Self Spouse Child
 Birthdate ____/____/____
 Insurance Co. Name & Address _____ Policy # _____
Plan Type: Single Husband/Wife or Parent/Child Parent/Children or Family
Coverage Type: Medical Drug Dental Vision

LIST APPLICANT AND ALL ELIGIBLE DEPENDENTS Copy of medical card required

| ADD | DELETE | RELATIONSHIP | DEPENDENT NAME | | | Birth Date (mo/day/yr) | Full-time Student | ID/SS No. | Enrolled under Medicare A & B Effective Date |
|--------------------------|--------------------------|---|----------------|-------|------|------------------------|---|-----------|--|
| | | | Last | First | M.I. | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Self <input type="checkbox"/> M <input type="checkbox"/> F | | | | ____/____/____ | | - - | ____/____/____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Husband <input type="checkbox"/> Wife | | | | ____/____/____ | | - - | ____/____/____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Son <input type="checkbox"/> Daughter | | | | ____/____/____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | - - | ____/____/____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Son <input type="checkbox"/> Daughter | | | | ____/____/____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | - - | ____/____/____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Son <input type="checkbox"/> Daughter | | | | ____/____/____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | - - | ____/____/____ |

SECTION 4

Do your dependents reside in your home?
 Yes No If No, give address: _____

Do you have a disabled dependent beyond initial limiting age?
 Yes No List Name(s): _____

Enrolled under Medicare? Yes No

Full-time students exceeding initial limiting age: (Must provide each semester to show Full-time student status)
 List Names _____ School Name and Address _____ Expected Graduation _____

SECTION 5

The Beneficiary selection applies to Life/Life with AD&D Insurance available through your Employer, if any. Selection(s) of Beneficiary(ies) is(are) not valid unless signed, dated and delivered to the Employer during your lifetime.

| Primary - Full Name | Address | SS# | Relationship | % of Benefit |
|-----------------------|---------|-----|--------------|--------------|
| | | | | |
| | | | | |
| Secondary - Full Name | | | | |
| | | | | |

SECTION 6

Applicant's Signature _____ Date ____/____/____

For ALL coverage enrollments a Certificate of Creditable Coverage MUST be provided.

INSURANCE DESIGN ADMINISTRATORS ENROLLMENT APPLICATION

SECTION 1

Your Last Name _____ First _____ M.I. _____

Your SS No. _____
 Single Married Divorced

In case of change due to Marriage: In case of change due to Divorce

Date of Marriage ____ / ____ / ____ Date of Divorce ____ / ____ / ____

Address _____
 Phone No. (____) _____ (____) _____

City _____ State _____ Zip Code _____

Employment Status: Active: Full-time Part-time Retired COBRA

Date of Employment: ____ / ____ / ____ Date of Retirement: ____ / ____ / ____

Employer Use Only

Group Name _____

Group ID _____ Employee Code _____

Effective Date Requested
 ____ / ____ / ____

Network _____ Division _____

Employer's Signature & Date _____

SECTION 2

| | | | | | | |
|--|----------|-----------------|--------------------------|---------------------------------|------------------------------|---------------------------|
| <input type="checkbox"/> New Enrollment/Reinstatement (complete Section 4) <input type="checkbox"/> Change Coverage to: (check new coverage) <input type="checkbox"/> Cancel Coverage: (check those that apply) <input type="checkbox"/> Add or Delete Dependent: (complete Section 4) <input type="checkbox"/> Change Enrollee's Information: (complete Section 1 with new information) REASON: _____ | Type | Option | Single | Husband/Wife or Parent/Child | Parent/Children or Family | Complement to Medicare |
| | Medical | Plan G | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Medical | Plan H | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Medical | Plan I | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Medical | Plan J | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Dental | \$750 – D | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Dental | \$1,250 – D/003 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Rx Copay | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Date of change: ____ / ____ / ____ | | | | | | |

SECTION 3

OTHER COVERAGE? (Inaccurate information may result in claim delay or denial.)
 Is there coverage under any other group health plan available to you or any member of your family?
 No Yes, Effective Date ____ / ____ / ____

If Yes; Policyholder Name & ID/SS No. _____ Relationship _____
 Self Spouse Child

Insurance Co. Name & Address _____ Birthdate ____ / ____ / ____

Policy # _____

Plan Type: Single Husband/Wife or Parent/Child Parent/Children or Family

Coverage Type: Medical Drug Dental Vision

LIST APPLICANT AND ALL ELIGIBLE DEPENDENTS

Copy of medical card required

| ADD | DELETE | RELATIONSHIP | DEPENDENT NAME | | | Birth Date (mo/day/yr) | Full-time Student | ID/SS No. | Enrolled under Medicare A & B Effective Date |
|--------------------------|--------------------------|---|----------------|-------|------|------------------------|---|-----------|--|
| | | | Last | First | M.I. | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Self <input type="checkbox"/> M <input type="checkbox"/> F | | | | ____ / ____ / ____ | | - - | ____ / ____ / ____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Husband <input type="checkbox"/> Wife | | | | ____ / ____ / ____ | | - - | ____ / ____ / ____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Son <input type="checkbox"/> Daughter | | | | ____ / ____ / ____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | - - | ____ / ____ / ____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Son <input type="checkbox"/> Daughter | | | | ____ / ____ / ____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | - - | ____ / ____ / ____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Son <input type="checkbox"/> Daughter | | | | ____ / ____ / ____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | - - | ____ / ____ / ____ |

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Do your dependents reside in your home?
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Do you have a disabled dependent beyond initial limiting age?
 Yes No List Name(s): _____

Enrolled under Medicare? Yes No

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 List Names _____ School Name and Address _____ Expected Graduation _____

SECTION 5

The Beneficiary selection applies to Life/Life with AD&D Insurance available through your Employer, if any. Selection(s) of Beneficiary(ies) is(are) not valid unless signed, dated and delivered to the Employer during your lifetime.

| Primary – Full Name | Address | SS# | Relationship | % of Benefit |
|-----------------------|---------|-----|--------------|--------------|
| | | | | |
| | | | | |
| Secondary – Full Name | | | | |
| | | | | |

Applicant's Signature _____ Date ____ / ____ / ____

For ALL coverage enrollments a Certificate of Creditable Coverage MUST be provided.