Group Enrollment / Change or Waiver Form

COBRA - If the individual is a continuee:
Qualifying Event_____ Date of Event _____

RELIANCE STANDARD
Life Insurance Company
a DELPHI company
MAILING ADDRESS:
P.O. BOX 82510, LINCOLN, NE 68501-2510
800-497-7044 / FAX: 402-466-0003

POLICY AND DIV. # 136- _____ CERT.# _____

NAME AND ADDRESS OF EMPLOYER (Policyholder) _____

1. TO ENROLL ☐ DENTAL ☐ EYE CARE ☐ TO TERMINATE ALL COVERAGES

EMPLOYEE INFORMATION: MARITAL STATUS ☐ SINGLE ☐ MARRIED

SOCIAL SECURITY NUMBER _____ DEPT.# _____

EMPLOYEE'S LAST NAME, FIRST, MI _____

DATE OF BIRTH _____ ☐ MALE ☐ FEMALE

FULL TIME DATE OF HIRE _____ ☐ REHIRE - REHIRE DATE _____

OCCUPATION _____

HOURS WORKED EACH WEEK _____ ARE YOUR EARNINGS PAID: ☐ HOURLY OR ☐ SALARIED

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

ARE YOU COVERED UNDER ANOTHER DENTAL INSURANCE PLAN? **EMPLOYEE: ☐ YES ☐ NO** **DEPENDENTS: ☐ YES ☐ NO**

ARE YOU COVERED UNDER ANOTHER EYE CARE INSURANCE PLAN? **EMPLOYEE: ☐ YES ☐ NO** **DEPENDENTS: ☐ YES ☐ NO**

DEPENDENT COVERAGE INFORMATION. LIST ALL ELIGIBLE DEPENDENTS TO BE ADDED OR DELETED. (Employee must be enrolled to cover dependents)

PRINT FULL LEGAL NAME (LAST, FIRST, M)	ADD	DROP	RELATIONSHIP	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER
1						
2						
3						
4						
5						
6						
7						

PLEASE SIGN (EMPLOYEE / POLICYHOLDER SIGNATURES)

As an employee, I hereby apply for, or waive (if indicated), group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary. *THE FOLLOWING APPLIES ONLY TO SECTION 125 FLEXIBLE BENEFITS PLANS:* I am signing up for coverage until the next enrollment period except in the case of a life event. This information was explained in the plan's solicitation materials which I have read and understand. I represent that the information I have provided is complete and accurate. The policyholder certifies the date of employment, job title, hours worked and salary information are correct according to the Policyholder's records.

X _____ _____
Employee Signature (Do Not Print) ***Date***

X _____ _____
Policyholder Signature ***Date***

In several states, we are required to advise you of the following: Any person who knowingly and with intent to defraud provides false, incomplete, or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, is guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim. (State-specific statements on back.)

EMPLOYEE LATE ENTRANT DATE _____

DEPENDENT LATE ENTRANT DATE _____

Effective Date	Class	Dep. Code

2. TO CHANGE

☐ **NAME CHANGE**

NEW NAME _____ OLD NAME _____

☐ **ADD DEPENDENT COVERAGE**

☐ IF DUE TO MARRIAGE, WHAT IS THE **DATE OF MARRIAGE?** _____

☐ IF DUE TO BIRTH/ADOPTION OF A CHILD, WHAT IS THE **DATE OF EVENT?** _____

☐ IF DUE TO LOSS OF COVERAGE, **DATE** AND **REASON:** _____

☐ OTHER, THE **DATE OF EVENT** AND PLEASE **EXPLAIN:** _____

☐ **DROP DEPENDENT COVERAGE** NUMBER OF DEPENDENTS STILL COVERED: _____

☐ DUE TO DIVORCE ☐ DUE TO DEATH ☐ DUE TO ANNUAL ELECTION PERIOD

☐ OTHER: PLEASE EXPLAIN: _____

EFFECTIVE DATE OF DROP: _____

3. TO WAIVE

IF YOU DO NOT WANT COVERAGE, COMPLETE THE WAIVER SECTION. THE WAIVER MAY NOT BE ALLOWED FOR THIS PLAN, CHECK WITH YOUR EMPLOYER.
I have been given an opportunity to apply for Group Insurance offered by my employer, and have decided not to accept the offer for:

☐ **myself** (does not apply to TRUST policies) ☐ **spouse only** ☐ **child(ren) only** ☐ **spouse and child(ren)**

because_____ Name of Insurance Co. & Employer of Dependent _____

Should I desire to apply for this group insurance in the future, I realize that a "late entrant" penalty may be applied.

Note for California Residents: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

Note for Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Note for Florida Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Note for New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Note for Georgia, Oregon and Virginia Residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Note for Pennsylvania Residents: 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.

TIPS FOR FILLING OUT THIS FORM

TO ENROLL

Missing, incomplete or illegible information can cause delays in adding new employees to the system and could create errors in billing. To ensure proper handling of your enrollment forms, please make sure the following areas are completed:

Policy Name and Group Number – to make sure plan members are added to the correct group.

Department/Division Numbers – so plan members are added in the proper locations, and appear in the appropriate section on the billing if the group has multiple departments or divisions.

Social Security Numbers – the most important identifier for plan members when calling in with claims or administrative questions. Please double check to make sure your social security number is accurate and written clearly.

Full-time Employment Date – needed so the correct effective date is calculated for new members.

Class Number – needed when the plan has more than one class of employees.

TO CHANGE

Changing Dependent Codes – When adding or dropping dependents, please note whether this change is because of a "life event" or for some other reason. (Examples of life events: marriage, birth of a child, divorce . . .) Please remember to include the date of the event. Late entrant status will be applied if a life event is not included. Be specific when changing status so all dependents who are still eligible will be covered.

IMAGING

In order to provide better service, our administration system utilizes image technology. In the image environment, we scan your enrollment forms into our system, making them easier and faster to access. Better quality forms help us to process your enrollments faster. Unfortunately, certain forms are difficult or impossible to scan. The following list of helpful hints will make your forms easier to scan:

Do:

1) submit clear, legible enrollment forms.

2) underline or circle important information.

3) use blue or black ink.

Don't:

1) submit dark copies as they appear black on imaging.

2) highlight, which blackens the area so it cannot be read.

3) write on the top or bottom margins. This information is not always captured on the image system.