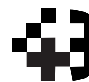
☐ New Enrollee ☐ Coverage Change ☐ Waiver (See Section 6)
☐ COBRA/MSE Enrollee ☐ Information Update



GROUP BENEFIT SERVICES, INC.
6 North Park Drive, Suite 310
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(410) 832-1300 (410) 832-1316 - F

EMPLOYEE ELECTION FORM

(This is not an application for insurance)

Every Item Must Be Completed

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

				Employer Section
Last Name	First Name	M.I.	Social Security Number - -	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	Tobacco Use (Y/N)	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 # ____

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 ADVANTAGEHRA
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 *or* willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly *or* 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:** ______________