



# EMPLOYEE ENROLLMENT/CHANGE FORM

WITHOUT Individual Medical Questions



Administrative Services by: Edison Health Solution, LLC  
100 S. Riverfront Drive, Suite 400 Jenks, Oklahoma 74037  
Phone: 800.967.2077



Marketed Exclusively by: Benefit Indemnity Corporation  
303 W Allegheny Avenue Towson, MD 21204  
Phone: 443.275.7400 www.benefitindemnity.co

**NOTICE: A person who knowingly and with intent to defraud files an application or statement of claim containing any false, incomplete or misleading information may be guilty of fraud, which is a crime. I understand and agree to answer all questions and complete all requested information thoroughly and truthfully. I understand that failure to do so may result in loss of coverage or denial of claims for any or all of those persons included on this application.**

➤ Each eligible employee must complete the entire form. ➤ This enrollment form must be completed in blue or black ink.

Please choose from the following:  New Applicant  Coverage Change  Information Update  COBRA Applicant  Add/Drop Dependent

**PLEASE FILL OUT THE ENTIRE APPLICATION TO AVOID PROCESSING DELAY.**

Applicant Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Group #: \_\_\_\_\_  
Employer Name: \_\_\_\_\_  
Division and/or Location: \_\_\_\_\_

**APPLICANT**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Marital Status:  Single  Married Gender:  Male  Female Height: \_\_\_\_\_ Ft. \_\_\_\_\_ In. Weight: \_\_\_\_\_ Lbs.  
Have you or any eligible dependent used tobacco products in the past twelve (12) months?  Yes  No  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home or Mobile Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Date Employed Full-Time: \_\_\_\_\_ Are you currently employed Full Time?  Yes  No  
Please indicate the number of hours worked weekly on a regular basis for this employer: \_\_\_\_\_

**FAMILY INFORMATION (PLEASE COMPLETE FOR ALL PERSONS TO BE COVERED BY THE HEALTH PLAN)**

First Name & M.I. (last name if different)	Gender	Date of Birth	Height	Weight	Social Security No.	Email Address
Spouse	<input type="checkbox"/> M <input type="checkbox"/> F	/ /			- -	
Child	<input type="checkbox"/> M <input type="checkbox"/> F	/ /			- -	
Child	<input type="checkbox"/> M <input type="checkbox"/> F	/ /			- -	
Child	<input type="checkbox"/> M <input type="checkbox"/> F	/ /			- -	
Child	<input type="checkbox"/> M <input type="checkbox"/> F	/ /			- -	

**COVERAGE INFORMATION**

Medical:  Employee  Family  Employee/Spouse  Employee/Child(ren) Requested Effective Date: \_\_\_\_\_  
*PLEASE BE SURE YOUR COVERAGE LEVEL SELECTED COORDINATES WITH THE DEPENDENT INFORMATION YOU PROVIDED ABOVE.*  
Medical Plan Selection: \_\_\_\_\_  
Do you have other coverage that will remain in place along with this coverage?  Yes  No (If YES, provide additional info/copy of ID card.)  
Dental:  Employee  Family  Employee/Spouse  Employee/Child(ren)  NONE

**REQUIRED-EMPLOYEE AGREEMENT/AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

I understand that the above answers shall be the basis for the Plan Sponsor (the employer shown on page one of application) to issue a Summary Plan Description. I declare all statements contained in this entire form about me and my dependents are true and correct and that no material information has been withheld or omitted. I understand and agree that the Plan Sponsor is not bound by any statement made by or to any agent unless written herein. I agree that no coverage will be effective until the date specified by the Plan Sponsor (the employer shown on page one of application).

I hereby apply for participation in my employer's employee welfare benefit plan (the Plan) for my dependents and myself listed above. To assist the Plan Sponsor with determining my creditable coverage, I hereby authorize those physicians, medical practitioners, hospital, clinics, veteran's administration facilities, medical information services, urgent care facilities, pharmacy, pharmacy benefit manager, health plan, and other medical or medically related entities, insurance or reinsurance companies, and consumer reporting agencies that have information available as to the present or former physical health condition, including drug or alcohol or domestic abuse, as well as diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, and/or treatment of me or my dependents to release to Amwins Accident & Health Underwriters, LLC, the claims or third party administrator, any other excess loss insurance carrier designated by the Plan, or its legal representative, any and all such information, including, but not limited to, medical records, health care provider notes, laboratory tests and results, diagnoses, treatment, and prognoses. I understand the information obtained by use of this authorization may be used to determine eligibility for issuance of health coverage and eligibility for benefits under existing health coverage or me and my dependents. This authorization is not applicable to psychotherapy notes. I agree that a photographic copy of this authorization shall be as valid as the original, and that this authorization shall be valid for 2 1/2 years from the date shown below. I understand the information obtained by use of this authorization may be used by the Plan Sponsor, claims or third-party administrator, and any excess loss insurance carrier designated by the Plan to determine eligibility for health coverage, and eligibility for benefits under an existing plan, for myself and my dependents. Any information obtained will not be released to any person or organization, except to reinsuring companies or other persons or organizations performing business or legal services in connection with my enrollment for the coverage, for any claim, for medical management purposes, or as may be otherwise lawfully required or as I may further authorize. I also understand that I have a right to revoke this authorization in writing at any time by sending written notice to 303 Allegheny Avenue, Towson, MD, 21204, except to the extent information has been released in reliance upon this authorization. Should I refuse to sign this authorization, I understand it may affect my enrollment in the benefit plan. All pages must be attached and complete, including this authorization for the application to be considered complete. Incomplete applications may be rejected.

I authorize my employer to deduct the necessary contribution toward the coverage. I reserve the right to revoke this deduction at any time upon my written notice subject to regulations or law. Coverage is effective only after approval and satisfaction of any probationary period and is contingent upon truthful completion of this enrollment form. In some states, any person who, knowingly and with intent to defraud, submits an application or files a claim containing any materially false information may be guilty of fraud, which is a crime. The Plan Sponsor reserves the right to terminate, modify or rescind coverage on any person because of the person's intentional material misrepresentation or fraud, including but not limited to, information requested in this form relating to me and my dependents.

I authorize Benefit Indemnity Corporation to contact me via the email address provided above with plan information and/or marketing materials that may provide educational information on my health benefits and any additional offers. I understand that my email address will never be shared with unrelated entities.

**This enrollment form should not be completed more than 60 days prior to the Plan Sponsor's requested effective date.** Date Signed: \_\_\_\_\_  
Print Name: \_\_\_\_\_ Applicant Signature: \_\_\_\_\_