THE HEALTH BENEFIT ALLIANCE

ENROLLMENT APPLICATION (Health Benefit Only)

☐ New
☐ Change

Benefits Administered by HBA Administrators

Employee - If you are applying for coverage with your employer's benefit plan, please complete Parts 2 - 6. If you do not desire coverage under your employer's plan, please complete Parts 2, 3 (as applicable) and 7. **Please print clearly.** Incomplete and/or illegible forms will be returned.

Part 1 - Employment Information (TO BE COMPLETED BY THE EMPLOYER ON BENELINK)

a) Company Name: _____ b) Subgroup: _____

c) Effective Date: _____ d) Employee Date of Hire_____

e) Salary: _____ f) Employee email address _____

Part 2 - Employee Information

a) Social Security Number: _____

b) Name: Last _____ c) First: _____ d) Middle: _____

e) Street: _____ f) Gender: ☐Male ☐Female

g) City: _____ h) Date of Birth: _____

i) State: _____ j) Zip: _____ k) Status: ☐Single ☐ Married ☐ Divorced ☐ Widowed

Part 3 - Coverage Information

a) Health Benefit Plan

- ☐ **ULTRA PLAN**
- ☐ **PLUS PLAN**
- ☐ **BASIC PLAN**
- ☐ **BRONZE**
- ☐ **SILVER**

b) Tier Coverage

- ☐ EE Only
- ☐ EE + Child(ren)
- ☐ EE + Spouse
- ☐ EE + Family

Part 4 - Dependent Information - Complete below unless you elected Single coverage in Part 3 above.

☐ Last Name	First Name	Middle Name	Date of Birth	Relationship	Gender	Social Security Number
a)			b)	c) Spouse	d)	e)
f)			g)	h)	i)	j)
k)			l)	m)	n)	o)
p)			q)	r)	s)	t)
u)			v)	w)	x)	y)

Part 5 - Other Coverage Information

a) Are you or any member of your family covered by any other group insurance, HMO Plan, or Federal program including Medicare?

Medical ☐ Yes ☐ No; **Dental** ☐ Yes ☐ No; **Vision** ☐ Yes ☐ No; **Prescription** ☐ Yes ☐ No (Complete below for Medicare)

b) If yes, Name of Carrier: _____ c) Policy ID#:_____

d) Address: _____

e) Effective Date: _____

f) Policyholder Name: _____

g) Are family members covered? ☐Yes ☐ No If yes, which ones? ☐Employee ☐Spouse ☐Children

If yes, is this Plan Primary (P) or Secondary (S) for: ☐P ☐S Employee ☐P ☐S Spouse ☐P ☐S Children

Part 6 - Request for Group Insurance

I have attached a copy of my certificate(s) of creditable coverage that may reduce my pre-existing waiting period ☐Yes ☐No

I hereby apply for insurance to which I am entitled issued by the Group. I meet the eligibility requirements of this plan and authorize the deduction from my earnings of any contribution I may be required to make toward the cost of the plan.

Employee's Signature: _____ Date: _____

Part 7 - Waiver for Group Health Insurance

Check the appropriate box below and then sign and date at the bottom.

I am declining coverage under this Plan as I currently have coverage under another group health plan. ☐ Yes ☐ No

I hereby certify that I have been offered an opportunity to become covered under the benefit plan sponsored by my employer and I have on behalf of myself, and/or my spouse and/or children decided NOT to take advantage of this offer.

Employee's Signature: _____ Date: _____

Employer's Signature/Verification: _____ Date: _____