

Date of Hire: _____

Effective Date: _____

Plan Selection

 I elect the following coverage for myself:
 \$500 Deductible
 \$2,000 (HSA) Deductible
 \$3,000 Deductible
 Dental
 Decline Coverage

Employee Information

 Name: _____ Gender: Male Female

Last Name
First Name
MI

 Home Address: _____

City
State
Zip

Social Sec No: _____ Birthdate: _____

Phone #: _____ Email Address: _____

 Marital Status: Single Divorced Married Legally Separated

Proof of Dependent Eligibility is required. Please provide a copy of Marriage/Birth Certificate, Court Order of Affidavit of Qualifying Domestic Partnership.

Dependent Information

Benefit Election	Name (Last, First, MI)	Other Coverage	Social Security No.	Birthdate	Gender	Add/Drop	Relationship to Employee
<input type="checkbox"/> Medical	Name: _____	<input type="checkbox"/> Yes	_____	_____	<input type="checkbox"/> M	<input type="checkbox"/> Add	_____
<input type="checkbox"/> Dental		<input type="checkbox"/> No			<input type="checkbox"/> F	<input type="checkbox"/> Drop	
If Child is over age 26, is child Disabled: <input type="checkbox"/> Yes <input type="checkbox"/> No							
<input type="checkbox"/> Medical	Name: _____	<input type="checkbox"/> Yes	_____	_____	<input type="checkbox"/> M	<input type="checkbox"/> Add	_____
<input type="checkbox"/> Dental		<input type="checkbox"/> No			<input type="checkbox"/> F	<input type="checkbox"/> Drop	
If Child is over age 26, is child Disabled: <input type="checkbox"/> Yes <input type="checkbox"/> No							
<input type="checkbox"/> Medical	Name: _____	<input type="checkbox"/> Yes	_____	_____	<input type="checkbox"/> M	<input type="checkbox"/> Add	_____
<input type="checkbox"/> Dental		<input type="checkbox"/> No			<input type="checkbox"/> F	<input type="checkbox"/> Drop	
If Child is over age 26, is child Disabled: <input type="checkbox"/> Yes <input type="checkbox"/> No							
<input type="checkbox"/> Medical	Name: _____	<input type="checkbox"/> Yes	_____	_____	<input type="checkbox"/> M	<input type="checkbox"/> Add	_____
<input type="checkbox"/> Dental		<input type="checkbox"/> No			<input type="checkbox"/> F	<input type="checkbox"/> Drop	
If Child is over age 26, is child Disabled: <input type="checkbox"/> Yes <input type="checkbox"/> No							
<input type="checkbox"/> Medical	Name: _____	<input type="checkbox"/> Yes	_____	_____	<input type="checkbox"/> M	<input type="checkbox"/> Add	_____
<input type="checkbox"/> Dental		<input type="checkbox"/> No			<input type="checkbox"/> F	<input type="checkbox"/> Drop	
If Child is over age 26, is child Disabled: <input type="checkbox"/> Yes <input type="checkbox"/> No							

Other Coverage

Please complete the following information if you or any dependent listed is covered under another health plan:

Covered Individual	Carrier Name & Phone No.	ID/Policy No.	Effective & Term Date	Coverage (Medicare, Medical, Dental, Vision)

Change

If Changing Coverage, please give reason for change: *(Please specify on pg. 1 what coverage you want to cancel)*

Drop Spouse/Dependent Date: _____ Reason: _____

Cancel Coverage (self) Date: _____ *(last day of coverage)* Medical Dental

Add Spouse/Dependent Reason: _____ Date, Marriage/Birth: _____

If adding Spouse of Domestic Partner, a copy of the Marriage Certificate or Affidavit of Qualifying Domestic Partner is required

If adding Dependent Child due to adoption, court order or legal guardianship, you must provide legal documentation.

Taking a Leave of Absence Date: _____ Continue Coverage during leave: Yes No

Returning from LOA Date: _____

Acceptance

This Application is made for benefits under the Heritage University Health and Welfare Plan for which I am eligible. Authorization is granted to deduct from my wages any premiums required to participate. I certify the above information to be correct and true to the best of my knowledge and that those listed as dependents qualify as such under the terms of the Plan. I understand that all entitlements to benefits are void, and coverage may be canceled or modified retroactively to its effective date if I have made intentionally false or misleading statements or answers on behalf of myself or any family member. I authorize any person or institution providing care or services, or any organization in possession of insurance benefit information to release any and all information providing care or services, or any organization in possession of insurance benefit information to release any and all information pertaining to the care or benefits provided to me or my dependents to HMA or its designated agent. This form replaces all previous forms and submissions I have made for coverage.

Applicant Signature: _____

Date: _____