EMPLOYEE ENROLLMENT FORM / REFUSAL FORM

www.gbs-tpa.com

INSTRUCTIONS FOR COMPLETING THIS FORM

1. **Misstatements, omissions, and illegible statements made on this form may cause you to lose coverage under this plan.**
2. This form must be completed by the **EMPLOYEE ONLY.**
3. Please **PRINT** clearly. **INITIAL & DATE** all corrections.
4. You must be a US Citizen or Legal Alien residing in the USA to be eligible for all coverage's under this Plan.

EMPLOYER INFORMATION

Adair County Government – Group: #40500

Plan Type: ☐Base ☐Buy-Up ☐Maxi-Care

Employment Location: ☐Road & Bridge ☐General Revenue ☐Assessment ☐Multi-County ☐P.A. Admin ☐Juvenile Grant ☐Law Enforcement General

Occupation: _____

☐Open Enrollment ☐New Hire ☐Employment Status Change:_____ Event Date:_____

EMPLOYEE INFORMATION

PLEASE PRINT CLEARLY (All fields must be completed in order to qualify for coverage) **PLEASE PRINT CLEARLY**

☐ Single ☐ Married ☐ Divorced

☐ I DECLINE ALL COVERAGE*

*Life benefit is still provided for those who decline all coverage, please complete page 2.

Name: _____ ☐ Male ☐ Female Date of Birth: _____ Hire Date: _____

Home Address: _____ City:_____ State:_____ Zip Code: _____

Social Security Number: _____ Home Phone #: _____ Cell Phone #: _____

E-mail Address: _____ Salary*:_____ Effective Date: _____

*****IMPORTANT DISCLOSURE AND COVERAGE INFORMATION *****

Please note that by enrolling in the coverage(s) available to you, any part of the benefits that you select that is NOT employer paid, you do hereby authorize your employer to reduce your salary by the amount necessary to cover the cost of the benefits you select.

Will you or any dependents enrolling be covered by any other Medical/Dental/Vision Insurance in addition to this Plan?: ☐Yes ☐ No

- If yes, who?: ☐Employee ☐Spouse ☐Child(ren) Please attach a **Certificate of Creditable Coverage** from that insurance company.

Benefit Enrollment Coverage Class	Medical/Rx	Voluntary Dental	Voluntary Vision	Employee & Dependent Life
Employee Only:	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	***Employer Paid* ($25,000)**
Employee/Children:	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	**Dependent Life $5,000 per Child $10,000 Spouse ☐Yes ☐No**
Employee/Spouse:	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	
Employee/Family:	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	

ENROLLING DEPENDENT INFORMATION (Only list dependents you are enrolling on this Plan)

Dep#	Relation to Employee	First Name, M. I., Last Name (if different*)	Gender (M / F)	Social Security Number	Date of Birth
1					
2					
3					
4					
5					

*Dependents with different last names from the employee will require additional proof (Marriage License, Proof of Guardianship, Divorce Decree, etc.) in order to become active under this plan.

PRIMARY LIFE INSURANCE BENEFICIARY INFORMATION					
First Name, M. I., Last Name	Date of Birth	SSN	Relationship	LIFE*	Additional Instructions
1				%	
2				%	
3				%	

*Total of Percentages must equal 100.

CONTINGENT LIFE INSURANCE BENEFICIARY INFORMATION					
First Name, M. I., Last Name	Date of Birth	SSN	Relationship	LIFE*	Additional Instructions
1				%	
2				%	
3				%	

*Total of Percentages must equal 100.

PLEASE READ CAREFULLY

SPECIAL ENROLLMENT NOTICE:
If you decline Medical, Dental, and/or Vision coverage for yourself, your spouse, or your dependents at this time for any reason, you may later be eligible to enroll yourself, your spouse and/or your newly acquired dependent(s) in Medical, Dental, and/or Vision coverage within 31 days of acquiring the dependent(s) through marriage, birth, adoption, or placement for adoption.

If you decline Medical, Dental, and/or Vision coverage for yourself or your dependents at this time because of coverage under other Insurance coverage, you or your dependents may later be eligible to apply for Medical, Dental, and/or Vision without penalty within 31 days after you or your dependents' other coverage ends by providing proof of loss of other Insurance coverage.

If you decline Medical, Dental, and/or Vision coverage for yourself, your spouse, or your dependents at this time, you may also enroll for coverage during Open Enrollment Periods that are specified by the Plan Sponsor preceding the annual renewal of the Plan each Plan Year.

ACA WAIVER ACKNOWLEDGEMENT:
I understand by waiving coverage of an ACA compliant and affordable health plan that I will be unable to secure a Marketplace subsidy. The Plan Sponsor will not be penalized by the Marketplace as a result of my waiving coverage under this Plan.

ELECTRONIC WAIVER:
GBS provides 24 hours a day, seven days a week access to your online employee benefits web portal located at: www.mygbshealth.com. By signing this form I understand that I have electronic access to a wide variety of Plan documentation including the Summary Benefit of Coverage (SBC) at any time.

I REPRESENT: (1) I am an employee of the participating employer and the persons for whom I am requesting coverage are US Citizens or Legal Aliens residing in the USA; (2) the statements and answers to the questions on this Enrollment/Refusal Form made by me are true and complete to the best of my knowledge; (3) I understand that the statements and answers to questions on the Enrollment/Refusal Form made by me and any subsequent information I provide are the basis for my coverage under my employer's Plan and coverage will not be effective until I am notified of my effective date; (4) if any controversy or claim is made arising out of or relating to a claim for benefits payable by the self-funded Plan it shall be settled by arbitration in accordance with the provisions of the Plan.

I AUTHORIZE: (1) any physician, medical practitioner, hospital, clinic, pharmacy benefit managers, Veteran's Administration, or other medical-related facility, Insurance agent, administrator, Insurance Company, reinsurer, consumer reporting agency, telephone interview Company, or my employer to release any information pertaining to my employment or to the health of myself or my dependents, including physical or mental disorders or the use of drugs and alcohol, to Group Benefit Services; (2) Group Benefit Services to release such information to any Insurance agent, Insurance Company, reinsurer, managed care organization, telephone interview Company, other Insurance support organization, or my employer; (3) my employer to deduct contributions from my earnings to be applied to the cost of this Plan; and (4) that benefits under this Plan be paid directly to any managed care provider utilized by me or my family.

I agree this authorization will be valid for two years from the date this form is signed and that a photocopy of this authorization is as valid as the original for my dependent(s) and/or for me.

Employee Signature: X _____ **Date Signed:** _____

(PLEASE DO NOT PRINT)

This authorization form will be valid for two years from the date this form is signed by me and that a photocopy of this executed authorization is as valid as the original for my dependent(s) and/or for me.