Group Marketing Services, Inc.

Group Insurance That Benefits Small Business

GROUP INSURANCE
NEWBORN ENROLLMENT FORM

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Please complete EACH section of this application in ink. There can be NO whiteout on this application.

Section 1 – Employee Information (REQUIRED)

Employee's Last Name	First	M.I.	Date of Birth	Social Security Number	☐Male ☐Female

Employer's Name: E-mail address:

Are you currently working full time hours? ☐Yes ☐No; If "NO", Reason:_____ Last day worked:_____ Return to work date:_____

If you have had a change in address

Mailing Address City State Zip Code

Marital Status: ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced Date:_____

Are you covered by other insurance? ☐No ☐Yes (including Medicare)

Policyholder Name & D.O.B.	Relationship	Name of Carrier	Type of Policy (Group, COBRA or Individual)	Date of Policy Start Date	Date of Policy End Date

Section 2 – Newborn(s) Information (REQUIRED)

if marital status is single, divorced or separated when adding a newborn, a Verification of Dependent Eligibility form is required with enrollment.

Newborn(s) Full Legal Name First Last	Gender	Date of Birth (MM/DD/YY)	*Social Security No.*	Coverage Election: * *If waiving coverage on an eligible dependent, sign the below waiver*
A.	☐Male ☐Female			☐Elect ☐Decline/Waive*
B.	☐Male ☐Female			☐Elect ☐Decline/Waive*

Is the child(ren) covered by any other insurance? ☐No ☐Yes

Dependents Covered	Policyholder Name & D.O.B.	Relationship	Name of Carrier	Type of Policy (Group, COBRA or Individual)	Date of Policy Start Date	Date of Policy End Date

Section 3 – Coverage Election and Waiver Information (REQUIRED IF WAIVING)

Waiver of Coverage Statement

If you decline / waive coverage for your dependents, there are only certain times in the future you may enroll yourself and/or your dependents in this plan.

- If you are declining enrollment for your dependents because they have other creditable health insurance coverage, you may enroll them in this plan in the future if the other coverage is terminated as a result of involuntary loss of eligibility. Enrollment must be made in writing and received at Group Marketing Services, Inc. within 30 days after your other coverage ends. "Loss of eligibility" includes loss of coverage due to legal separation, death, divorce, termination of employment or reduction in hours. It does not include a loss of coverage due to failure to pay premiums, termination for cause such as making a fraudulent claim or waiver of other coverage. If you decline coverage because you have COBRA continuation coverage under another plan, you must exhaust your COBRA coverage before you may enroll in this plan.
- You may in the future enroll yourself and/or your dependents in this plan, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption. Enrollment must be made in writing and received by Group Marketing Services within 30 days after the marriage, birth, adoption or placement for adoption.

You may in the future enroll your dependents in this plan during your group's Open Enrollment period only if and/or your dependents have no other health insurance coverage. Open Enrollment is a one month period four (4) months prior to your group's renewal date. Enrollment must be made in writing and received at Group Marketing Services, Inc. during the month of Open Enrollment.

I hereby certify that the benefits provided under the group insurance made available to me by my Employer have been explained to me and that I have been given an opportunity to apply within 31 days of my eligibility period. I have elected to waive that opportunity. I voluntarily decline to participate in the group insurance Plan(s) selected above that I am otherwise eligible to participate in.

*Employee Signature (If waiving):_____ Date:_____

Section 4 – Statement of Understanding (REQUIRED)

By signing this application, I represent that all my answers are complete and accurate, and that I understand and agree to the following conditions:

- No independent producer, agent or employee of the insurer, or my employer can change any part of this application or waive the requirement that I answer all questions completely and accurately.
- The insurer may, at its discretion, request supplemental information from me, any family member listed on this application or any health care provider.
- On behalf of myself and all enrolled family members, I understand if the insurer discovers any intentional misrepresentation, omission or concealment of fact in obtaining coverage that was or would have been material to the insurer's acceptance of a risk, extension of coverage, provision of benefits or payment of any claim, the insurer may take action against me or my employer, including but not limited to increasing premiums.
- All dependents listed in the dependent section of this form are eligible as defined by the Plan (i.e. biological, adopted or step child) and agree to notify my employer promptly if and when there is a change in my dependent status.
- I authorize my employer to deduct the required contribution, if any, from my earnings.
- Faxed or copied applications are not considered application and are not accepted. Application must be complete and have an original signature.
- If this application is approved, coverage for myself and any eligible family members named on this application will begin on the date assigned by the insurer.
- Coverage is only in effect after receiving written approval from the insurance company.
- Application MUST be received in our office within 30 days of the Special Event (newborn's date of birth) or coverage cannot be offered.
- My employer's master group policy is the document that sets forth all terms of my coverage, and no independent producer, agent of other person can change the terms of the master group policy, an of its amendments, or this application, except with an amendment issued expressly for that purpose and signed by an authorized office of the insurer.
- I understand this application will become part of the contract between the insurer and my employer.
- I affirm that I have reviewed all answers given on this application and, regardless of whether an independent producer or other person has filled out the answers for me, I verify that the answers are true and complete.
- Any person who knowingly, and with intent to injure, defraud or deceive any insurance company, files an insurance application containing any false, incomplete or misleading information is guilty of a criminal act punishable under law.

AUTHORIZATION for the release of information

To: (1) Any licensed physician, medical practitioner, hospital, clinic, or other medically related facility; (2) any insurance company or health maintenance organization (or similar type organization or institution); and (3) the Medical Information Bureau. I authorize you to give any data, information or records you may have about me or my mental or physical health to Assurity Life Insurance Company or Group Marketing Services, Inc or its subsidiaries. This authorization includes information related to all conditions, treatments and diagnoses including, but not limited to: HIV/AIDS, alcohol and drug use, mental/nervous conditions. This authorization also applies to any dependent applying for coverage on this application. A photocopy of this form will be as valid as the original.

Employee/Applicant's Signature:_____ Date:_____

Spouse/Applicant's Signature (if applicable):_____ Date:_____

Section 5 – Employer Approval (REQUIRED)

Company Name	☐Management ☐Non-Management	☐Hourly ☐Salaried	☐Union ☐Non-Union	Commissioned Only? ☐Yes ☐No	Base Salary Plus Commission? ☐Yes ☐No
Employment Status: ☐Full Time ☐Part Time ☐Seasonal ☐Contracted		Earnings: $		☐Hourly ☐Weekly ☐Bi-Weekly ☐Semi-Monthly	

Full Time Hire Date	Lay-Off Date	Leave of Absence Date	Reduction in Hours Date	Termination Date	Return to Work Date	Re-Hire Date

Approval Signature:_____ Date:_____