

The Employee Benefit Service Center

Application and Enrollment Form

Instructions: Please complete all information and sign where indicated at the bottom. An incomplete application will delay enrollment.

Type of Application		<i>Please check your plan document for details.</i>	For The EBSC Use
<input type="checkbox"/>	New Hire	Enrollment within 31 days of your benefit eligibility date.	
<input type="checkbox"/>	Special Enrollment	Enrollment for loss of other coverage, marriage, births or adoption.	
<input type="checkbox"/>	Late Enrollment	Enrollment after 31 days of your benefit eligibility date.	
<input type="checkbox"/>	Other		

* Enrollment may be subject to a pre-existing condition limitation, which can be reduced or eliminated by prior health insurance coverage if you were covered within 63 days from the date the prior coverage terminated to the enrollment date in this plan. The enrollment date is the date the waiting period starts or the actual date of enrollment, whichever is earliest. If you had coverage within the 63 day timeframe, you should have a certificate from the previous plan that verifies the coverage. This certificate should be sent with this enrollment form.

Did you have coverage as described within the 63 day period? **No** **Yes** If, yes please attach a certificate.

Group Number	Group Name	Location	Hire Date	Effective Date of Coverage
--------------	------------	----------	-----------	----------------------------

Social Security #	First Name	Middle	Last Name	Sex	Marital Status	D/O/B
-------------------	------------	--------	-----------	-----	----------------	-------

Street Address	City	State	Zip Code	Home Phone Number
----------------	------	-------	----------	-------------------

Please Select Coverage Desired, this choice is final and can only be changed by completing a benefit change of status form.

<input type="checkbox"/> Single Medical	<input type="checkbox"/> Single Dental	<input type="checkbox"/> Life _____ (salary)
<input type="checkbox"/> Enrollee + Child Medical	<input type="checkbox"/> Enrollee + Child Dental	<input type="checkbox"/> Short Term Disability
<input type="checkbox"/> Enrollee + Spouse Medical	<input type="checkbox"/> Enrollee + Spouse Dental	<input type="checkbox"/> Long Term Disability
<input type="checkbox"/> Family Medical	<input type="checkbox"/> Family Dental	<input type="checkbox"/> Voluntary Life _____

Life Insurance: Primary and Secondary designation					Voluntary Life Insurance: Primary and Secondary designation				
Name:	First	Last	Relationship	DOB	Name:	First	Last	Relationship	DOB
Primary					Primary				
Secondary					Secondary				

Please list all dependents to be insured, attach an additional sheet if necessary.

First Name	MI	Last Name	Sex	Date of Birth	Social Security #	Relationship	Student
							Y N
							Y N
							Y N
							Y N

Are you or any of your dependents, who are enrolling for coverage, covered by other health insurance?			Yes	No
If yes please provide name of applicant	Name and address of insurance company		Effective Date	

I hereby enroll for coverage, as checked above, for which I am eligible. I authorize my employer to deduct my contributions, if any, from my earnings. I authorize any person or organization having records or knowledge of me or my family, or of our health, to give The Employee Benefit Service Center or its legal representative, licensed physicians or practitioners, hospitals, clinics or medically related facilities, insurance companies and others who have a legitimate need for such information for the purpose of review, investigation or evaluation. I agree that a photo copy of this authorization shall be valid as the original. I understand and agree that benefits payable for any pre-existing condition(s) may be limited unless reduced by certification of prior coverage. I understand that failure to comply with the precertification or other cost management procedures of the plan may result in a reduction of benefits. I hereby certify that the information given above is true and complete to the best of my knowledge. I understand that any mis-statements, omissions or misrepresentation may result in the rescission of any insurance coverage issued in connection with the employee benefit plan and may result in no coverage.

Please mail completed form to: The Employee Benefit Service Center PO Box 8130 South Charleston, WV 25303	Employee Signature	Date
	I have reviewed this application and certify that all information is true and correct to the best of my knowledge.	
	Employer Signature or Authorized Personnel	Date