

# 2017-2018 Medical Declaration Form

(Acknowledgement to be completed annually for compliance purposes.)

SECTION 1 – ENROLLMENT EVENTS		Please check all that apply – If you are declining coverage, complete Sections 1, 2, 3, 5, 9 & 10.
<b>Enrollment Action:</b>  <b>Effective Date:</b>  / /	<input type="checkbox"/> New Enrollee <input type="checkbox"/> Add Dependent Are you applying as a result of a special enrollment event? <input type="checkbox"/> Yes <input type="checkbox"/> No Event: <input type="checkbox"/> Marriage <input type="checkbox"/> Birth, Adoption, Placement for Adoption <input type="checkbox"/> Court Order <input type="checkbox"/> Loss of Other Coverage <input type="checkbox"/> Other: _____  Indicate Event Date: ____ / ____ / ____	<input type="checkbox"/> Cancel Enrollee <input type="checkbox"/> Cancel Dependent List names of those canceling in Section 4 below Event: <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Terminated Employment <input type="checkbox"/> Dependent Child Exceeds Age Limit <input type="checkbox"/> Gain of Other Insurance <input type="checkbox"/> Other, _____ Indicate Event Date: ____ / ____ / ____ Cancel Coverage: <input type="checkbox"/> Medical

SECTION 2 – EMPLOYEE INFORMATION		Complete Even if Declining Coverage.			
Last Name	First Name	MI (opt)	Suffix	Date of Birth / /	Social Security Number - - - -
Mailing Address – Street – Apt #		City		State	Zip
Email Address	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Business Phone #	Cell Phone #		Home Phone #
Name of Employer: <b>IMPRIMIS GROUP, FREEMAN+LEONARD AND BRAVO TECH</b>		Date of Employment: / /	Do you normally work at least 30 hours per week? <input type="checkbox"/> Yes <input type="checkbox"/> No		

SECTION 3 – SELECT COVERAGE	
<b>BCBS Medical Plan:</b> <input type="checkbox"/> BCBS – BlueChoice BlueEdge H.S.A. MMH3 (\$5000 Deductible) Coverage Level: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee Child(ren) <input type="checkbox"/> Employee/Family	

SECTION 4 – DEPENDENT COVERAGE INFORMATION				
Spouse's Name	Spouse's Date of Birth / /	<input type="checkbox"/> Male <input type="checkbox"/> Female	Spouses SSN: - -	
Child's Name	Child's Date of Birth / /	<input type="checkbox"/> Male <input type="checkbox"/> Female	Child's SSN - -	
Child's Name	Child's Date of Birth / /	<input type="checkbox"/> Male <input type="checkbox"/> Female	Child's SSN - -	
Child's Name	Child's Date of Birth / /	<input type="checkbox"/> Male <input type="checkbox"/> Female	Child's SSN - -	

SECTION 9 – DECLINATION OF HEALTH COVERAGE – complete this section if you have declined a coverage in section 2, for yourself or any eligible dependent.
This is to certify the available coverage has been explained to me. I have been given the opportunity to apply for the coverage offered to me and my eligible dependents and have voluntarily elected to decline the coverage as indicated below. If I desire to apply for coverage at a later date, I understand there may be a delay in the effective date of the coverage as well as a pre-existing condition waiting period.
Employee _____ Reason for declining: <input type="checkbox"/> Other Group Coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other, explain: _____ Spouse _____ Reason for declining: <input type="checkbox"/> Other Group Coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other, explain: _____ Child(ren) _____ Reason for declining: <input type="checkbox"/> Other Group Coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other, explain: _____

SECTION 10 – COVERAGE CONDITIONS
<ul style="list-style-type: none"> <li>I am an employee of IMPRIMIS GROUP, FREEMAN+LEONARD or BRAVO TECH working a minimum of 30 hours per week and meet the eligibility requirements for myself and dependents listed on this form, and am eligible to participate in the coverage(s) afforded by my Employer's plan. On behalf of myself and my dependents listed on this Enrollment Application, I am applying for those coverage(s) for which I am eligible. I state that the information given on this Enrollment Application is true and correct. I understand and agree that any intentional misinterpretation of a material fact made by me may invalidate my coverage(s).</li> <li>Only those coverage(s) and amounts for which I am eligible will be available to me. I understand that if this Enrollment Application is accepted, the coverage(s) will become effective in accordance with the provisions of the Contract(s)/Plan(s).</li> <li>I agree that my Employer acts as my agent. I authorize necessary payroll deductions by Employer, if any, to cover the cost of my coverage(s).</li> <li>I understand that my participation in the coverage(s) is subject to any future amendment. I also understand that all notices given to my Employer are applicable to me.</li> <li>I understand that benefit elections will be effective for the entire plan year, and may not be changed until the next open enrollment unless an approved status change is experienced. I also understand that any changes I wish to make resulting from a qualified status change event must be requested in writing and submitted to my HR representative within 30 days from the date of the event.</li> </ul>
Applicant's Signature _____ Date: _____