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Online Enrollment: www.selfinsuredplans.com

SECTION 1 – TO BE COMPLETED BY EMPLOYER			
Employer	Group #	Location/Class	
<input type="checkbox"/> New Enrollment	Date of Hire	Late Entrant <input type="checkbox"/> Yes <input type="checkbox"/> No	Effective Date:
Amount Life EE \$	Dep. Life \$	Other Life \$	Annual Salary \$
<input type="checkbox"/> Hourly <input type="checkbox"/> Salaried <input type="checkbox"/> Other	Plan Elected	<input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> EPO <input type="checkbox"/> Other:	
<input type="checkbox"/> Change	Date of Qualifying Event	Please indicate the nature of change/qualifying event:	
<input type="checkbox"/> Termination	Date of Termination	Effective Date	

SECTION 2 – TO BE COMPLETED BY EMPLOYEE			
Employee's Name (Last, First, Middle)			Social Security Number
Home Address (Street)		City	State Zip
Telephone Number	Gender M F	Birth Date	Occupation/Title
Marital Status (circle one) Married Single Divorced Widowed Legally Separated			
Coverage elected (Circle coverages desired in each category for yourself & the dependents listed below).			
Employee	Medical	Dental	Vision Disability Other:
Spouse	Medical	Dental	Vision Disability Other:
Dependent Children	Medical	Dental	Vision Disability Other:
Full Name (indicate the name(s) of your dependent(s) below)	Social Security #	Sex	Birth Date Spouse's Employer and Phone # Child's College, City, State
Spouse			
Child			
Child			
Child			
Child			
Do you or your dependents have other medical and/or dental coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who is covered?			
Type of coverage _____ Medical _____ Dental _____ Both			
Name of carrier:			
Are you or your dependents eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No Who is eligible?			
Is any applicant disabled/handicapped? <input type="checkbox"/> Yes <input type="checkbox"/> No Name (If yes, please provide documentation)			
Beneficiary Full Name	Relationship	Social Security #	Address
Contingent Beneficiary Full Name	Relationship	Social Security #	Address
Accepting Coverage			
I am enrolling for coverage under my employer's health benefit plan. I have read the authorization statement on the reverse side of this form and acknowledge the authorization is in effect until all claims are settled under this plan.			
Employee's Signature		Date	
X _____		X _____	
Declining Coverage			
Check here if you are declining because you have other coverage. _____			
I waive health coverage for myself (and dependents, if any) and I have read the waiver statement on the back of this form.			
Employee's Signature		Date	
X _____		X _____	

INSTRUCTIONS FOR COMPLETING THE FORM

General Instructions

Section 1 is to be completed by the employer and Section 2 is to be completed by the employee. The employee name and social security number must be completed for all transactions. The yellow copy should be retained by the employer and the pink by the employee. Send the white copy to: S/P at the address on the front of this form.

Additional Instructions for New Enrollments

Employer - complete the first four lines in Section 1.

Employee - to enroll, complete Section 2 in full and sign the Accepting Coverage section after reading the statement below. To decline, sign the Declining Coverage section after reading the statement below.

Additional Instructions for Changes

Employer - complete the Change in Section 1 including the date of the qualifying event and the nature of change.

Employee - complete only the information which has changed. For example, to report a marriage and add a spouse, complete the marital status, coverage selected for spouse, Spouse Name, Social Security Number, sex, birth date, employer information, if the spouse has other coverage and Medicare eligibility. Sign the Accepting Coverage Section. For a change of address, complete the new address and sign the Accepting Coverage Section.

Additional instructions for Terminations

Employer - complete the Termination box in Section 1 including the Date of Termination and Effective Date.

IMPORTANT INFORMATION REGARDING YOUR ENROLLMENT OR WAIVER OF COVERAGE

Declining Coverage Statement (if coverage is waived)

This is to acknowledge that the available coverages have been explained to me by my employer. I have been given the opportunity to apply for the available coverages and have elected not to enroll myself (and/or dependents, if any).

Further, I understand if I am waiving coverage at this time due to other coverage, that I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after my other coverage ends. In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Accepting Coverage Statement

I hereby (1) request coverage for the Group Health & Life Plan, if applicable, for which I am, or may become eligible; (2) authorize my employer to make the necessary deductions for the contributions, if any, required for the Health & Life Plan, or agree that the contributions be added to my dues, and (3) designate the beneficiary named on this form to receive the proceeds, if any, payable in the event of my death. I hereby certify that the foregoing statements are true and correct to the best of my knowledge and I also authorize any hospital, physician or other persons who have attended me or examined me or my dependent(s) to disclose, when requested, any or all information with respect to my illness, injury or medical history to the claims payer, utilization review company and/or case management company. A photostatic copy of this authorization shall be considered as effective and valid as the original. I understand that payments will be made directly to the hospital or physician for services rendered unless paid receipts are presented.