Integon National Insurance Company
Indiana Small Group Insurance
Employee Enrollment Form

EMPLOYER INFORMATION (must be completed)	
Company Name/DBA:	Company Address:

You must complete this form in its entirety in order for you or your dependents to be covered under the employer's group health plan. If you are waiving coverage for yourself or your dependents, it must be clearly indicated on this form. If you do not complete this form in its entirety for yourself or your dependents at least 5 business days prior to the effective date, you or your dependents may not be eligible for coverage until the next open enrollment period.

TO BE COMPLETED BY EMPLOYEE (if applying or waiving coverage)

GROUP HEALTH PLAN:	GROUP NUMBER:

A - EMPLOYEE (Primary Applicant)

Legal Name:	(Last)	(First)	(MI)

Social Security Number:	Sex: ☐ M ☐ F	Birth Date (mm/dd/yyyy):	**Average number of hours worked per week?**	**Date employed Full-Time: (MM/DD/YYYY)**
Home Street Address		City	State	Zip
Mailing Address (if different)		Mailing Address City	Mailing Address State	Mailing Address Zip
Home Phone: Cell Phone:		Work Phone Best Time to Call:	Email Address: **Job Title**:	

Status: ☐ Single ☐ Married Employee Status: ☐ W2 ☐ 1099 ☐ Owner/Partner	Check One: ☐ Full-Time ☐ Part-Time ☐ Retiree ☐ COBRA COBRA effective date(mm/dd/yyyy) _____	Earnings Basis: ☐ Salaried ☐ Hourly ☐ Commission

NEW ENROLLMENT or WAIVER, please check one:

☐ New Hire ☐ Special Enrollment Event:_____Date: (mm/dd/yyyy) _____
☐ Re-hire ☐ COBRA
☐ Open Enrollment ☐ Waiver of Coverage (complete section B)
☐ New Group ☐ Other: _____

B - WAIVER OF COVERAGE – DO NOT COMPLETE IF ENROLLING FOR COVERAGE
Complete and sign if waiving any or all coverages for self. All Eligible Employees must be listed as either enrolling or waiving coverage when first eligible.

Indicate the waiver reason below.

☐ Individual Medical ☐ Medicare/Medicaid ☐ COBRA/Continuation ☐ Tricare ☐ Spouse's/Parent Employer Plan
☐ Cost/Do not want (NO health coverage will exist) ☐ Other: _____

Neither I nor my dependents have been induced or pressured to decline coverage by my employer, the agent, or Integon National Insurance Company. My dependents and I have waived such coverage of our own accord.

Signature:	Date:
Printed Name:	Date employed Full-Time:

C – ONLY TO BE COMPLETED BY ADDITIONS TO EXISTING GROUPS OR FOR CHANGES TO EXISTING COVERAGE

Requested effective date: / / (Subject to Underwriting approval)

1. Groups with multiple medical plans, indicate which plan you are requesting.* Medical Plan #:_____

**Please contact your employer for the plan options/descriptions which are identified on your employer's billing statement and/or quote.*

2. If enrolling outside of your employer's open enrollment period, indicate the special enrollment event (documentation may be required)

a) ☐ Marriage ☐ Birth ☐ Adoption ☐ Court ordered (copy of court order required)

For any event in 2(a), list date of event ____/____/____

b) ☐ Divorce/Separation ☐ Involuntary loss of coverage, state reason for loss_____
☐ COBRA/Continuation exhausted
☐ Other_____

For any event in 2(b), list coverage termination date _____/_____/_____

**Proof of Creditable Coverage is required.*

D – PERSONS TO BE COVERED

(Include yourself and all family members to be insured. If more space is needed, attach an additional sheet)

☐ Employee Only	☐ Employee Spouse	☐ Employee Child(ren)	☐ Family: Employee, Spouse, & Child(ren)	
Include yourself & all family members to be insured **Last Name**	**First Name**	**Relationship & Sex**	**Date of Birth (MM/DD/YYYY)**	**Social Security Number**
		Employee ☐ M ☐ F	XXXXXX	XXXXXXXXX
		Spouse [/Domestic Partner] [/Civil Union] ☐ M ☐ F		
		Child ☐ M ☐ F		
		Child ☐ M ☐ F		
		Child ☐ M ☐ F		
		Child ☐ M ☐ F		
		Child ☐ M ☐ F		

Please explain if any child listed above is not your naturally born child, legally adopted child, a child subject to legal guardianship, or stepchild.

Name _____ _____

Name _____ _____

E – ADDITIONAL INSURANCE COVERAGE INFORMATION

1. Will any current medical plan remain active if coverage is approved?	☐ Yes ☐ No
a) If "Yes", for whom? b) Please provide carrier and ID/Group number: _____	
2. Are you, your spouse or any dependent children currently covered under Medicare Part A, B, or D?	☐ Yes ☐ No
a) If "Yes", for whom?	
b) If yes, will coverage remain active if the coverage for which you are applying is approved?	☐ Yes ☐ No

F – *** NOTICE OF FEDERAL MANDATES ****** INITIAL NOTICE ABOUT SPECIAL ENROLLMENT RIGHTS*****

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your, or your dependents', other coverage).

You must, however, request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents.

Effective April 1, 2009 a federal mandate took effect that allows for a Special Enrollment Period, which is outlined below.

A Special Enrollment Period will be provided for an employee and his/her dependent(s) who are eligible, but not enrolled, for coverage under the terms of the employer's plan to enroll for coverage if either of the following conditions are met:

a) The employee or dependent is covered under a Medicaid plan or under a State child health plan and coverage of the employee or dependent under that plan is terminated as a result of loss of eligibility for coverage. The request for coverage under the employer's group health plan must be submitted no later than 60 days following the date of termination of such prior coverage under Medicaid or a State child health plan.

b) The employee or dependent becomes eligible for assistance under a Medicaid plan or under a State child health plan. The request for coverage under the employer's group health plan must be submitted no later than 60 days following the date the employee or dependent is determined to be eligible for such assistance.

G – APPLICATION Authorization and Signature:

I hereby represent that I am an employee of the participating employer and that the statements and answers to the questions on this enrollment form are true and complete to the best of my knowledge and belief. I understand that the statements and answers contained herein will be used by Integon National Insurance Company to determine eligibility for insurance for myself and persons listed on this enrollment form as my spouse[domestic partner][/civil union] and/or dependent children.
When applicable, I authorize my employer to deduct contributions from my earnings to be applied to the cost of insurance.

I understand that (1) the answers given will be the basis of any coverage provided; (2) if not eligible for coverage, I, my spouse[domestic partner][/civil union] and/or dependent children are not entitled to benefits; (3) if I, my spouse[domestic partner][/civil union] and/or dependent children waive coverage and decide to apply for coverage at a later date, evidence of eligibility may be required and benefits may be deferred for a specified period of time; and (4) coverage will not be effective until my employer receives notice that this enrollment form has been approved by Integon National Insurance Company.

I agree that a copy of this authorization will be valid as an original.

Any person who knowingly and with intent to defraud any insurance company or other person submits an enrollment form for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be found guilty of insurance fraud, which is a crime and may be subject to fines or imprisonment under applicable state law.

I understand that this authorization is required in order to enable Integon National Insurance Company to make eligibility or enrollment determinations relating to me, my spouse and/or my dependents or for Integon National Insurance Company to make underwriting or risk rating determinations. If I refuse to sign or revoke this authorization, Integon National Insurance Company may refuse to consider my application for enrollment.

Employee/Primary Applicant Signature:_____

Date: _____