

BENEFIT SUPPORT, INC.
ENROLLMENT APPLICATION FOR GROUP INSURANCE

(Please print Clearly or Type)

Employer _____ Group # _____ Location # _____

Employee Name _____ SS# _____

Address _____
 Street City State Zip

Sex _____ Date of Birth _____ Occupation _____ Date Hired _____ Effective Date _____

Have you been continuously covered under a medical plan for at least 12 months? Yes [] No []

Have your dependent's been continuously covered under a medical plan for at least 12 months? Yes [] No []

(Please provide a Certificate(s) of Creditable Coverage)

Selected Coverage:

Employee Only: Medical [] Dental [] Employee & Spouse: Medical [] Dental []
 Employee & Children: Medical [] Dental [] Family: Medical [] Dental []
 EMPLOYEE LIFE COVERAGE [] DEPENDENT LIFE COVERAGE []

Please list all dependents to be covered:

Dependent's Full Name	Relationship	Date of Birth	Sex	Social Security #

Are you or any of your dependents covered by any other group health coverage? Yes [] No []

If yes, Name of Insured _____ SS# _____

Employer _____ Policy Number _____

LIFE AD&D COVERAGE

Amount of Life and AD&D Coverage _____ Salary _____

Beneficiary _____ Relationship _____

COMPLETE ONLY FOR WAIVER OF GROUP INSURANCE COVERAGE

The group program has been offered to me and after seriously considering its benefits, I have decided:

[] (a) not to enroll myself or dependents in the Program [] (b) not to enroll my dependents in the Program

I understand that if I desire to participate in the Program at some future date, my coverage or my dependent's coverage may be postponed and/or subject to a pre-existing condition exclusion for up to 18 months. For further information on the late addition policy please contact your employer.

I hereby authorize my employer to make the necessary deductions from my wages or salary for the contributions, if any, required of me for the group health and/or life coverage. I also state that to the best of my knowledge, all of the above information is true and that all of the dependents listed are my legal dependents. I authorize any health care provider or medically related facility, insurance or reinsurance company or employer having certain information about my dependents or me to release such information to Benefit Support, Inc. or its designated representative. I also authorize Benefit Support, Inc. to release any information obtained to re-insurance companies or other persons or organizations performing business or legal services in connection with my application, claim or as may be otherwise lawfully required. This authorization will be valid for two years and a copy shall be as valid as the original.

If you are declining enrollment for yourself and your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. 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, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Date Signed

Employee's Signature