ENROLLMENT FORM

Employer Information

Employer Name	Group Number	Date of Hire	Effective Date
Search Pros Staffing			

Employee Information

Last Name	First Name	Gender ☐ Male ☐ Female	Social Security #
Date of Birth	Salary		Occupation

Address	City	State	ZIP

Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Separated	Email Address	Phone Number	Reason for Enrollment ☐ Open Enrollment ☐ New Hire ☐ Family Status

Benefit Elections

Fixed Indemnity Plan	Dental & Vision Package	Short-Term Disability	Life and AD&D Insurance
☐ Standard ☐ Preferred ☐ WAIVE COVERAGE	☐ Enroll ☐ WAIVE COVERAGE	☐ Enroll ☐ WAIVE COVERAGE	☐ Enroll ☐ WAIVE COVERAGE

Coverage Tier
☐ Employee ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

Dependent Information

Last Name	First Name	MI	Social Security #	Date of Birth
Spouse				
Dependent				
Dependent				
Dependent				

Life Insurance Beneficiary*

Beneficiary	Date of Birth	Relationship

*Only needs to be completed if enrolling in Life and AD&D Insurance

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Current/Prior Coverage

Have you or your dependents been covered under this employer's plan or any other major medical plan(s) at any time in the past 12 months? ☐ Yes ☐ No

If yes, who was covered?	Name of Carrier	Policy/ID#	Effective Date
☐ Employee ☐ Spouse ☐ Child(ren)			

Will prior coverage remain active when coverage under this employer's plan goes into effect?	If no, what is the term date?
☐ Yes ☐ No	

Qualified Medical Child Support Order

Are any of your dependents covered by a Qualified Medical Child Support Order? ☐ Yes ☐ No (if yes, complete below)

Custodial Parent	Name of Dependent	Dependent's Social Security #	Dependent's Date of Birth

Dependent's Residential Address	City	State	Zip

Waiver of Coverage

I elect to waive coverage for myself? ☐ Yes Reason

I elect to waive coverage for my dependents? ☐ Yes Reason

Names of dependents for which to waive coverage:

Signature	Date

Employee Agreement

I hereby apply for participation in my employer's Employee Health and Welfare Benefit Plan for myself and/or my dependents listed above and agree to abide by the terms, provisions, and limitations as outlined by the Plan Sponsor in the issuance of the Plan Summary Description. I declare all statements contained in this form are true and correct and that no material information has been withheld or omitted. I understand that any misstatements or failure to report information that is material to my qualification and participation may be used as a basis for rescission of my participation and/or denial of payment of claims. I agree no benefits will be effective until the date specified at the top of this form.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, the Veterans Administration, the Medical Information Bureau (MIB), or any other organization, institution, insurance or reinsurance company, to disclose and release any information in its possession about the medical history, mental or physical condition or treatments of myself and/or my dependents to Fringe Benefit Group or its designee. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Signature	Date