Enrollment Form

Employer Information:

Employer Name: | Location or Division:

Please Indicate: ☐ Open Enrollment ☐ New Hire ☐ Re-Hire Other:

Employee Information:

Please indicate your employment status: ☐ Hourly: Hours per week ________ ☐ Salaried ☐ Reinstatement of Coverage

Last Name	First Name	MI	Social Security Number	Primary Phone
Street Address	City	State	Zip Code	County

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated

Email Address	Gender ☐ M ☐ F	Date of Birth	Hire Date	Effective Date

Plan Benefit Elections:

Medical Plan: ☐ $500 Deductible PPO ☐ $2000 Deductible PPO $5000 Deductible PPO ☐ $6,350 Value Plan

Enrolling For: ☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child ☐ Family

Please list covered dependents below (use additional pages, if necessary):

Relation to Employee	First Name	Last Name	Social Security Number	Date of Birth	Sex
Spouse					☐ M ☐ F
Dependent Child					☐ M ☐ F
Dependent Child					☐ M ☐ F
Dependent Child					☐ M ☐ F

Do You or Your Other Dependents Have Other Medical Coverage? ☐ Yes ☐ No If yes, please indicate: ☐ Medicare ☐ Medicaid ☐ Other

Name of Insured	Social Security Number	Name of Other Employer	Policy or Group No.

Name of Other Insurance Company	Address of Other Insurance Company

AUTHORIZATION OR REFUSAL

I certify that the information I have provided is true and correct. I authorize my personal and family medical providers to release copies of treatment records to the plan administrator's representatives to facilitate any treatment and payment for care (a photocopy of this authorization shall be as valid as the original).

☐ **I request to be enrolled in the coverage elected above.**

☐ **I decline all coverage (If declining, you must complete the Declination form).**

☐ **I authorize my employer to deduct from my pay any contribution required. I understand and agree that my contribution will be deducted from my pay on a pre-tax basis, if applicable.**

Employee Signature ______________________________________ **Date** ______________

Declination Form

Employer Information:	
Employer Name:	Location or Division:
Please Indicate: ☐ Open Enrollment ☐ New Hire ☐ Re-Hire Other:	

Employee Information:				
Last Name	First Name	MI	Social Security Number	
Street Address	City	State	Zip Code	County
I acknowledge that I have been given the opportunity to elect coverage under my Employer's group medical plan and I hereby decline coverage as indicated below.				
Reason for Declining Coverage: ☐Other Group Coverage ☐Medicare ☐Medicaid ☐Other, explain:				

- I understand that I will not be eligible to enroll in the medical plan until the Plan's next open enrollment period unless I experience one of the following: (a) a change in my family status; (b) a loss of other insurance coverage; (c) other such special enrollment event that may occur prior to the next open enrollment period. I understand that if I have a new dependant as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll my dependent(s) if I request enrollment within 30 days of the event.

- I understand that if I am declining enrollment for myself or my dependents because of other health insurance coverage, I may be able to enroll myself and my dependents in this plan if I or my dependents lose eligibility for that other coverage (or if the employer imposes a new requirement to pay premiums on a previously 100% Employer-paid plan). However, I must request enrollment within 30 days of the other coverage ending (or after the employer stops contributing 100% of the premium toward the other coverage), or withing 60 days of the loss of my dependents' eligibility for coverage under Medicaid or CHIP.

- I understand that a request for coverage prior to the next open enrollment period must be due to an event that is permitted by regulation and by the Plan.

I understand that if I am not enrolled for coverage under a health plan, I will be subject to the IRS penalty tax unless I acquire at least Minimum Essential Coverage as defined by the U.S. Department of Labor.

Employee Signature **Date Signed**

capitol ADMINISTRATORS
A LUCENT HEALTH COMPANY

Employee Medical History Questionnaire

Please provide the following information for yourself as well as for any family members on whose behalf you are electing medical coverage (use additional pages, if necessary):

Full Name of Employee/Family Member	Relationship to Employee	Date of Birth	Height (ft., in)	Weight (lbs.)

On behalf of yourself and each of your family members listed above, please respond to each of the questions listed below.

Yes	No	
☐	☐	1. Are you or any of your family members listed above currently confined or have you been confined to a hospital/other institution in the past five years?
☐	☐	2. Are you or any of your family members currently pregnant or scheduled for / planning on having any inpatient or outpatient surgeries or other procedures in the next twelve months following the signing of this form?
☐	☐	3. Are you or any of your family members listed currently unable to work, attend school, perform daily tasks, etc. due to illness / injury?
☐	☐	4. Are you or any of your family members listed above on COBRA? Have you or any of your family members recently received or are you / they expecting to receive a COBRA notification letter?
☐	☐	5. Are you or any dependent enrolling for coverage currently taking medication?
		6. Within the past 5 years, have you or any of your family members listed above been diagnosed with and / or received treatment for any or the diagnoses listed below –
☐	☐	Arthritis, Bone, Joint, Spine, Musculoskeletal Disorders, Muscle or Connective Tissue Disorder
☐	☐	Bone Marrow or Organ Transplants
☐	☐	Cancer, Tumor, or Polyp
☐	☐	Cirrhosis, Hepatitis or other disease of the Liver
☐	☐	Collagen Disease including Lupus
☐	☐	Digestive System Disorder, including Disease of the Colon, Gallbladder, Pancreas, Stomach, Esophagus or Intestines
☐	☐	Diabetes, Thyroid Disorder or Disease of the Endocrine System
☐	☐	Drug Abuse, Alcohol Abuse, Fetal Alcohol Syndrome or Psychiatric Disorder
☐	☐	Eyes, Ears, Nose, Throat Disorder, or Meningitis
☐	☐	Genetic, Growth, or Development Disorder
☐	☐	Heart, Circulatory Disorder, Blood Disorder (including High Blood Pressure) or Edema
☐	☐	Immune System Disorder, including AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus)
☐	☐	Metabolic and Nutritional Disorders (including Hypercholesterolemia)
☐	☐	Quadriplegia, Paraplegia, Hemiplegia or Congenital Disorder
☐	☐	Neurological Disorder, including Alzheimer's Disease, Brian Disorders, Cerebral Palsy, Epilepsy, Migraines, Parkinson's Disease, Seizures or Multiple Sclerosis
☐	☐	Reproductive System Disorder including Infertility Treatment
☐	☐	Respiratory Disorder or Sleep Disorder
☐	☐	Rheumatic Fever or Cystic Fibrosis
☐	☐	Urologic Disorders or Renal Disorders (including Renal Failure)
☐	☐	Vascular Disorders including stroke, CVA (Cerebro Vascular Accident) or TIA (Transient Ischemic Attack)

Employee Medical History Questionnaire

If you answered "Yes" to any of the above questions, please provide the details below. Should you need more space, please attach an additional page to this form and identify the continuation of your remarks with the corresponding question number. Wherever possible, provide the dollar amounts initially charged by the medical providers before your insurance company paid benefits.

Question # (1-6)	Name of Employee / Family	Date of Treatment / Event	Diagnosis or Medical Condition	Details: Medical or Rx Services Received and / or Planned, Treatment Plan, Prognosis & Approximate Cost

To the best of my knowledge, I believe the above information is true and correct. I understand that false or inaccurate information may result in the termination of coverage or the non-payment of benefits.

Employee Signature____ **Date Signed**________________