Auxiant
Your Integrated Benefits Partner
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ENROLLMENT FORM

SearchPros

EMPLOYER USE ONLY

☐ New Employee ☐ Annual/Open Enrollment

☐ Special Enrollment

Date of Hire:_____

Effective Date:_____

Group: **SearchPros Staffing S1049**

Applicant's Name:	Last	First	Middle	Sex

Applicant's Street Address	City	State	Zip Code

Date of Birth	Primary Phone Number ( )	Secondary Phone Number ( )	Social Security Number

Email Address

COVERAGE REQUESTED

Medical: ☐ Single ☐ EE + Spouse ☐ EE +Child(ren) ☐ Family	Department/Location:
Number of Hours Worked Per Week: _____	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐Separated ☐ Domestic Partnership (if applicable)

PPO Network: ☐ CIGNA	Plan Option: ☐ PLAN B - $500 Deductible PPO ☐ PLAN E - $2,000 Deductible PPO ☐ PLAN G - $5,000 Deductible PPO ☐ PLAN H - $6,350 Value Plan

COMPLETE THE FOLLOWING INFORMATION FOR EACH PERSON TO BE COVERED

All Dependents listed must meet the plan definition of an eligible dependent.

	Relationship	Full Name	Date of Birth	Sex	Social Security Number	Other Insurance Coverage (please check)
01	Self					
02	Spouse					
03						
04						
05						
06						

Are you required by a court decree to cover any of the above listed dependents? ☐ Yes ☐ No

If yes, please attach a copy of the court papers indicating the requirement.

I hereby authorize any provider of health care services, claim administrators, insurers, and others who have a legitimate need for such information for the purpose of review, investigation, or evaluation of a claim, to supply each other with information about my health status and health care services provided to me. I hereby attest the information shown above is accurate to the best of my knowledge. I realize that false information or omissions of information in this application may result in cancellation of coverage and may be grounds for the plan sponsor to collect damages. I agree that a photographic copy of this authorization is as valid as the original. If applicable, I authorize payroll deductions for my responsibility of the premiums.

Employee Signature:_____ Date:_____

COVERAGE WAIVER SECTION- Complete this section ONLY if you are NOT electing coverage

Please check the appropriate box:

☐ I am waiving medical coverage because I have medical coverage elsewhere.

☐ I am waiving medical coverage and do not have coverage elsewhere.

Employee Signature:_____ Date:_____