EMPLOYEE ENROLLMENT / WAIVER FORM

INSTRUCTIONS FOR COMPLETING THIS FORM

1. All fields must be completed by the **EMPLOYEE.** Please **PRINT** clearly. **INITIAL & DATE** all corrections.
2. You must be a US Citizen or Legal Alien residing in the USA to be eligible for all coverage's under this Plan.
3. **Misstatements, omissions, and illegible statements made on this form may cause you to lose coverage under this plan.**

EMPLOYER INFORMATION

Cooper County Government #70100

Employment Location: ☐General ☐Road & Bridge ☐Assessment ☐911 ☐LEC

EMPLOYEE INFORMATION

Employee Name	Date of Birth		Hire Date
Street Address	City	State	Zip Code
Email Address	Job Title		Annual Salary
Gender ☐ Male ☐ Female	Marital Status ❑ Single ❑ Married ❑ Divorced		
Social Security Number	Phone Number		

***IMPORTANT DISCLOSURE AND COVERAGE INFORMATION ***

Please note that by enrolling in the coverage(s) available to you, any part of the benefits that you select that is NOT employer paid, you do hereby authorize your employer to reduce your salary by the amount necessary to cover the cost of the benefits you select.

Will you or any dependents enrolling in this Plan be covered by any other Medical Insurance in addition to this Plan?:
☐Yes ☐ No

- If yes, who?: ☐Employee ☐Spouse ☐Child(ren) Please attach a **Certificate of Creditable Coverage** from that insurance company.

Benefit Enrollment Coverage	Medical/Rx Plans	Voluntary Dental Plan	Voluntary Vision Plan	Employee & Dependent Life Plan
EMPLOYEE	**☐Base ☐BuyUp ☐MaxiCare ☐None**	**☐Yes ☐No**	**☐Yes ☐No**	**Employer Paid $25,000**
EE/CH(REN)	**☐Base ☐BuyUp ☐MaxiCare ☐None**	**☐Yes ☐No**	**☐Yes ☐No**	**Dependent Life $5,000 per Child $10,000 Spouse ☐Yes ☐No**
EE/SP	**☐Base ☐BuyUp ☐MaxiCare ☐None**	**☐Yes ☐No**	**☐Yes ☐No**	
EE/FAM	**☐Base ☐BuyUp ☐MaxiCare ☐None**	**☐Yes ☐No**	**☐Yes ☐No**	

Benefit Enrollment Coverage	Voluntary Life	LTD
EMPLOYEE	☐_____	☐Yes ☐No
CH(REN)	☐_____	N/A
Spouse	☐_____	N/A
		N/A

DEPENDENT INFORMATION (Only list dependents you are enrolling on this Plan)					
Dep.#	Relation to Employee	First Name, M. I. Last Name (if different*),	Gender (M / F)	Social Security Number	Date of Birth
1					
2					
3					
4					

*Dependents with different last names from the employee will require additional proof (Marriage License, Proof of Guardianship, Divorce Decree, etc.) in order to become active under this plan

PRIMARY LIFE INSURANCE BENEFICIARY INFORMATION					
First Name, M. I., Last Name	Date of Birth	SSN	Relationship	LIFE*	Additional Instructions
1				%	
2				%	
3				%	

*Life column must equal 100%

CONTINGENT LIFE INSURANCE BENEFICIARY INFORMATION					
First Name, M. I., Last Name	Date of Birth	SSN	Relationship	LIFE*	Additional Instructions
1				%	
2				%	
3				%	

*Life column must equal 100%

IMPORTANT:

SPECIAL ENROLLMENT NOTICE:

If you decline medical and/or dental coverage for yourself, your spouse, or your dependents at this time for any reason, you may later be eligible to enroll yourself, your spouse and/or your newly acquired dependent(s) in medical and/or dental coverage within 30 days of acquiring the dependent(s) through marriage, birth, adoption, or placement for adoption.

If you decline medical and/or dental coverage for yourself or your dependents at this time because of coverage under other health Insurance coverage, you or your dependents may later be eligible to apply for medical and/or dental coverage without penalty within 30 days after you or your dependents' other health coverage ends, **but only if you state on the Coverage Declination Form that other health coverage is the reason for declining coverage.** The penalty for failure to state that other health coverage was the reason for declining this coverage will be a 6-month waiting period under this Plan after you apply for coverage hereunder.

ELECTRONIC WAIVER:

GBS provides 24 hours a day, seven days a week access to your online employee benefits web portal located at: www.gbs-tpa.com . By signing this form I understand that I have electronic access to a wide variety of Plan documentation including the Summary Benefit of Coverage (SBC) at any time.

I REPRESENT: (1) I am an employee of the participating employer and the persons for whom I am requesting coverage are US Citizens or Legal Aliens residing in the USA; (2) the statements and answers to the questions on this Enrollment/Refusal Form made by me are true and complete to the best of my knowledge; (3) I understand that the statements and answers to questions on the Enrollment/Refusal Form made by me and any subsequent information I provide are the basis for my coverage under my employer's Plan and coverage will not be effective until I am notified of my effective date; (4) if any controversy or claim is made arising out of or relating to a claim for benefits payable by the self-funded Plan it shall be settled by arbitration in accordance with the provisions of the Plan.

I AUTHORIZE: (1) any physician, medical practitioner, hospital, clinic, pharmacy benefit managers, Veteran's Administration, or other medical-related facility, Insurance agent, administrator, Insurance Company, reinsurer, consumer reporting agency, telephone interview Company, or my employer to release any information pertaining to my employment or to the health of myself or my dependents, including physical or mental disorders or the use of drugs and alcohol, to Group Benefit Services; (2) Group Benefit Services to release such information to any Insurance agent, Insurance Company, reinsurer, managed care organization, telephone interview Company, other Insurance support organization, or my employer; (3) my employer to deduct contributions from my earnings to be applied to the cost of this Plan; and (4) that benefits under this Plan be paid directly to any managed care provider utilized by me or my family.

I agree this authorization will be valid for two years from the date this form is signed and that a photocopy of this authorization is as valid as the original for my dependent(s) and/or for me.

☐ I hereby certify that I am **declining** enrollment in the group health plan for ☐myself and/or ☐my dependents. I (or they) currently have other health insurance coverage- **attach proof of coverage**; or
☐I hereby certify that I am **declining** enrollment in the group health plan for ☐myself and/or ☐ my dependents. I (or they) do not currently have other health insurance coverage.

Employee Signature: X_____ **Date Signed:** _____

(PLEASE DO NOT PRINT)