MEDICAL & DENTAL ENROLLMENT FORM

183 MM32 - BASE ☐ **183 MM18 – BUY-UP** ☐ **183 MMH3-HDHP** ☐ **183 DENTAL** ☐

Employer:__**July Business Services, LLC**__ Group Number:__**183**__ Hire Date:___________

☐ Add ☐ Change ☐ Termination ☐ Correction Date:______________________ Reason:____

Employee's Name (Please Print Full Name):____ ☐ Male ☐ Female

☐ Active ☐ COBRA

Social Security Number: ______________________Employee's Birthdate:____________________Marital Status:_____________

Home Address:____Apt #:_______________

City:_____________________________________ State:____________ Zip:______________ Home Phone:______________________________

Do you have any other health or dental coverage? ☐ No ☐ Yes – What Insurance Company? ________________________________

MEDICAL

I Request Employee Health Coverage: ☐ Yes ☐ No

I Request Dependent Health Coverage: ☐ Yes ☐ No

I Request to Opt out of Health Coverage: ☐ Yes

DENTAL

I Request Employee Dental Coverage: ☐ Yes ☐ No

I Request Dependent Dental Coverage: ☐ Yes ☐ No

A Dependent Child **MUST** be less than age 26. If not, is child disabled? ☐ Yes – Complete Disabled Dependent Form

In order to enroll a Dependent you **MUST** complete Dependent information below.

Name:	**Date of Birth:**	**Sex**	**Social Security No.:**	**Relationship**
Does this Dependent have any other health or dental Coverage? ☐ **No** ☐ **Yes – What Insurance Company?**				
Name:	**Date of Birth:**	**Sex**	**Social Security No.:**	**Relationship**
Does this Dependent have any other health or dental Coverage? ☐ **No** ☐ **Yes – What Insurance Company?**				
Name:	**Date of Birth:**	**Sex**	**Social Security No.:**	**Relationship**
Does this Dependent have any other health or dental Coverage? ☐ **No** ☐ **Yes – What Insurance Company?**				
Name:	**Date of Birth:**	**Sex**	**Social Security No.:**	**Relationship**
Does this Dependent have any other health or dental Coverage? ☐ **No** ☐ **Yes – What Insurance Company?**				
Name:	**Date of Birth:**	**Sex**	**Social Security No.:**	**Relationship**
Does this Dependent have any other health or dental Coverage? ☐ **No** ☐ **Yes – What Insurance Company?**				
Name:	**Date of Birth:**	**Sex**	**Social Security No.:**	**Relationship**
Does this Dependent have any other health or dental Coverage? ☐ **No** ☐ **Yes – What Insurance Company?**				
Name:	**Date of Birth:**	**Sex**	**Social Security No.:**	**Relationship**
Does this Dependent have any other health or dental Coverage? ☐ **No** ☐ **Yes – What Insurance Company?**				

I am an Employee of the Employer named above, eligible to participate in the coverage(s) offered through my Employer. On behalf of myself and any dependents listed on this application, I apply, or as indicated, decline to apply for those coverage(s) for which I am eligible. I state that the information given as part of my Application is true and correct. I understand and agree that any incorrect statements material to the risk and knowingly made by me in this Application will invalidate my coverage(s) and that all statements made by me shall be deemed representations and not warranties.

I understand that even though I may have applied for certain coverage(s) listed on this Application, only those coverage(s) and amounts for which I am eligible will be available to me. I understand that if this Application is accepted and contributions are made, the coverages(s) will become effective in accordance with the provisions of the Plan(s) offered by my Employer.

I authorize my Employer to deduct from my wages or salary my portion, if any, of the contributions as they become due. I agree that my Employer acts as my agent in all dealings with the Plan(s) and that all notices given to him are binding upon me. I also agree that my participation in the coverages(s) and the authorizations and agreements stipulated herein are subject to any future amendments of the Plan(s).

To facilitate consideration of this Application for coverage(s), I authorize any hospital, physician, dentist, provider, insurance carrier, or other entity to give the Plan(s), upon request, any information covering the health condition of any person included under coverage whenever the information is considered necessary by the Plan(s) for proper disposition of the Application or of a claim submitted for payment.

I understand that (1) the health coverage I am applying for may be subject to a Preexisting Condition exclusion for a period of time as specified in the Plan(s) offered by my Employer; and (2) Preexisting Condition means abnormal physician or mental condition, whether active or inactive, which, depending on the Plan(s) offered by my Employer, either (a) existed before the patient became a Covered Person, or (b) caused the Covered Person to be seen or treated by a medical practitioner prior to the effective date of the Covered Person's coverage, including all deformities, ailments, or prior injuries which may thereafter become aggravated by subsequent injury or disease.

I agree that should I or any covered Dependent sustain an injury alleged to have resulted from the actions of the third party, I will repay to the Plan, out of any monetary recovery all amounts paid by the Plan(s) in connection with such injury.

Signature:____ Date:____________________________