GROUP ENROLLMENT FORM

GROUP NUMBER	LOCATION/ BRANCH	EMPLOYER
S2502		RSNA –

LAST NAME	FIRST NAME	M.I.	SOC. SEC. #	DATE OF BIRTH	SEX
					☐ MALE ☐ FEMALE

HOME STREET ADDRESS	CITY	STATE	ZIP	HOME PHONE #	EMAIL ADDRESS
				( ) -	

MARITAL STATUS	OCCUPATION	EARNINGS	REASON FOR ENROLLMENT
☐ Married ☐ Separated ☐ Single ☐ Divorced	 DATE OF HIRE	$__________ PER ☐HR ☐WK ☐MO ☐YR	☐New Employee ☐Open Enrollment ☐Rehire: Date:__________ ☐ Court Order ☐ Loss of Other Coverage ☐Other: __________

IF YOU DO NOT WANT COVERAGE FOR YOURSELF OR YOUR DEPENDENTS, COMPLETE "WAIVER OF COVERAGE" AT THE BOTTOM

PLAN ELECTION	MEDICAL/DENTAL/VISION COVERAGE
☐ PLAN I $750 Single/$1,500 Family Deductible ☐ PLAN II $500 Single/$1,000 Family Deductible ☐ PLAN III $250 Single/$500 Family Deductible	☐ Employee ☐ Employee + Spouse ☐ Employee + Child ☐ Family

COMPLETE IF DEPENDENT COVERAGE IS REQUESTED

RELATIONSHIP	NAME	DATE OF BIRTH	FULL TIME STUDENT if applicable	DEPENDENT SOC. SEC. # (required)	OFFICE USE ONLY
			☐ YES ☐ NO		
			☐ YES ☐ NO		
			☐ YES ☐ NO		
			☐ YES ☐ NO		

Please provide the following information for yourself and your spouse.

A) Did any other group health insurance terminate for you or your dependents within the past 62 days? ☐ Yes ☐ No

B) Do you or your dependents currently have other health insurance? ☐ Yes ☐ No

If Yes to (A), attach certificate of creditable coverage for prior periods. If Yes to (B), give name of policyholder, policy #, name of insured, insurance company and, if applicable, termination date.

The following information is required for Medicare Secondary Payer reporting.

A) Are you or your dependents currently on Social Security disability and/or on Medicare? ☐ Yes ☐ No

If yes, please provide the following details-Date of Social Security Disability entitlement, Name of Medicare beneficiary, Medicare Claim Number, Medicare effective date.

BASIC LIFE BENEFICIARY

I hereby direct payment of any death benefit under the Plan to the beneficiary listed below. Unless otherwise provided, if more than one beneficiary is designated in any one class, each beneficiary in the same class shall share equally.

First Name/Middle Initial/Last Name — Relationship — Beneficiary Social Security Number

I hereby enroll for coverage for which I am now or may become eligible under the employer sponsored group plan and hereby authorize my employer to deduct from my earnings the required contributions, if any. I understand that if my plan is a grandfathered plan, any adult child who is eligible for coverage under other employer-sponsored health coverage is not eligible for coverage under this plan until January 1, 2014 and hereby certify that any adult dependent child for whom coverage is requested is currently not eligible for any other employer-sponsored health coverage.

Signature of Employee **Date**

WAIVER OF COVERAGE

I have decided not to apply for coverage offered as checked below. I understand that I may not be eligible for such coverage at a later date if the Plan does not cover late enrollees. If the Plan allows open enrollment, I may be subject to a pre-existing condition exclusion period.

MEDICAL ☐ Self ☐ Dependent(s) **LIFE** ☐ Self ☐ Dependent(s)
DENTAL ☐ Self ☐ Dependent(s) **LTD** ☐ Self ☐ Dependent(s)

I decline such coverage because:

☐ My spouse is employed by__________________________ and is insured for similar health benefits.
Company's Name

☐ My children have health coverage under (plan or policy name)__________________________

☐ Other reasons (explain)__________________________

Signature of Employee **Date**

The following applies only if your group plan is subject to the Health Insurance Portability and Accountability Act of 1996.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.