



7801 E. Bush Lake Rd.-Suite 240
Bloomington, MN 55439

BENEFIT ENROLLMENT APPLICATION/INITIAL CLAIM STATEMENT

Employer Name			Group #	Loc/Div	Office Use Only
Employee Last Name	First	MI	Social Security #		Phone #
Street Address					___ Male ___ Female
City	State	Zip	Date of Birth		Marital Status
Date of Hire:	Full-Time Date:	Pay Period: ___ Weekly ___ Bi-Weekly ___ Monthly ___ Semi-Monthly	Job Title		Annual Salary

REQUEST FOR GROUP COVERAGE - CHECK BENEFITS DESIRED OR INDICATE WAIVER OF COVERAGE:

Medical: ___ Single ___ Family ___ Waive Medical Coverage New Hire _____
 Dental: ___ Single ___ Family ___ Waive Dental Coverage (if applicable) Change _____
 Disability: ___ STD ___ LTD ___ Waive STD/LTD (if applicable) Other _____
 Life: ___ Employee ___ Dependent ___ Waive Emp/Dep Life (if applicable) Effective _____

List EACH Dependent To Be Covered - First Name & Middle Initial - Include Last Name IF DIFFERENT than Employee's

Dependent Name	Relationship to Employee	Date of Birth	Social Security #	Gender	Effective Date
	Spouse				
1					
2					
3					
4					
5					

Employee's Life Insurance Beneficiary Name (If Applicable) _____ Relationship to Employee _____

OTHER COVERAGE INFORMATION

Is your Spouse Employed? ___ Yes ___ No If yes, Employer Name & Address: _____

Your health plan coverage includes a COORDINATION OF BENEFITS provision. To process your claim(s), we need the following information.

1. Do you or any family members have other group: A. Medical coverage? ___ Yes ___ No B. Dental coverage? ___ Yes ___ No
 C. Vision coverage? ___ Yes ___ No with orthodontia? ___ Yes ___ No

2. Are you or any family member covered by: A. Medicare? ___ Yes ___ No B. Non-group coverage? ___ Yes ___ No

If the answer to any of the above questions is "YES", please complete the section(s) below.

Name of Family Member with Other Coverage:	Name of Other Insurance Plan:
Birthdate:	
Employment Status of Individual: ___ Active Employee ___ Retiree	Coverage is For: ___ Medical ___ Dental ___ Vision
Address You Send Your Claims To:	
This Coverage Includes: ___ Insured Only ___ Spouse ___ Child(ren)	City State Zip
Name of Employer Providing Other Coverage: City/State	Numbers Identifying You To Plan: Effective Date of Coverage:

CHILD CUSTODY INFORMATION

If you or your spouse have ever been divorced or legally separated, please indicate who has custody of your child(ren):
 ___ Father ___ Mother ___ Other _____ Date Awarded _____

Has the parent **WITHOUT** custody been mandated by court decree to provide coverage of the dependent child(ren)? ___ Yes ___ No

If "YES", what other coverage has been provided? _____

I hereby make application for or waive coverage as indicated above. I understand I will be covered under the terms of the group plan/policies sponsored by my employer.

I authorize that any contribution I may be required to make for the cost of such coverage may be deducted from my earnings on a pre-tax basis, unless I specify otherwise in writing (if applicable).

I have read this application in its entirety and certify the information is accurate and complete. I understand and agree that any false statements or omissions may void any Benefit Plan(s) issued based on this application. I further understand a person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

EMPLOYEE SIGNATURE: X _____ DATE: _____