



MEDICAL CLAIMS SERVICE, INC.

Group Enrollment Form

Group # B50023

Name of Insurance Carrier

The carrier indicated above Life, AD&D, LTD and Weekly Income Insurance when applicable.

- Initial, Change (please check one), Special, Late

Beneficiary, Address, Add spouse and/or dependents, Delete spouse and/or dependents

Date Prior Plan Coverage Ended:

Certificate of Creditable Coverage Received

- Termination Date, Reinstatement Date, Date Cobra Began

Waiver of Coverage

Name of Employer: Perry-Hocking ESC
Group #: B50023 Location #: OHIO

Employee's Name: Last First MI
Employee's Address:
City: State: Zip:
Phone #: E-mail:

Sex: M F
Date of Birth: Month Day Year

Social Security Number

Marital Status: Single, Separated, Widowed, Married, Divorced

Date of Marriage: Month Day Year
Occupation:

Salary \$ per yr.
Hourly \$ per hr.
Date Employed Full Time: Month Day Year

I am applying for coverage as follows:

- Medical Dental Life AD&D LTD WI Vision
Single Coverage
Family Coverage

(LIST SPOUSE AND DEPENDENTS BELOW)
*Life, AD&D, LTD, and Weekly Income are the only Insured coverage when applicable.

I hereby request any group coverage's for which I am or may become eligible authorize deduction from my earnings or any required contributions and designate the stated beneficiary to receive any benefits thereunder resulting from my death. I certify that all information shown above is correct to the best of my knowledge and belief.

Employee's Signature Date

I am actively at work hours per week.

Other Insurance Information

Is Your Spouse Employed Elsewhere? Yes No

Name of Spouse's Employer

Address of Spouse's Employer

Spouse's Date of Birth

Name of Medical Ins. Co. Policy #

Name of Dental Ins. Co. Policy #

Spouse Only: Medical Dental

Spouse & Dependents: Medical Dental

Beneficiary Information

Beneficiary's Name (Last) (First) (MI)

Relationship to Applicant Beneficiary's Birthdate

Table with 9 columns: Spouse/Dependents' Names, Relationship, Social Security Number, Date of Birth, Sex, Full Time Student over 18, School Attending, Date of Grad, Disabled Y/N

*You must attach a completed Dependency Questionnaire for each child that is not your natural child.

Waiver of Group Coverage

I have been given an opportunity to apply for group coverage, and after careful consideration, I have decided NOT to participate for the following coverage's:

- Medical Dental Life AD&D LTD WI Vision
Single Cov.
Family Cov.

RIDER 2

Check if you are declining coverage because you have other health coverage. (If coverage is declined for this reason, you may enroll in the plan within 30 days after you lose this other coverage).

I understand that if my family members and/or I do not enroll within 31 days of first becoming eligible (or, if coverage is declined due to other health coverage, within 30 days of losing other health coverage) (1) my family members and/or I may not enroll in the plan until the next open enrollment period, (2) the application will be subject to the terms and conditions of the plan in effect at the later enrollment and (3) coverage for pre-existing conditions may be excluded under the plan for up to 18 months.

Signature of Employee Date

FOR MEDICAL CLAIMS SERVICE, INC. USE ONLY

DATE RECEIVED:

Effective Date:

Coverage:

COMMENTS: