Employee Enrollment Form

Administered By: GETTYSBURG HEALTH ADMINISTRATORS
404 Baltimore Street, P.O. Box 1060 Gettysburg, PA 17325-1060

☐ New Enrollment
☐ Add Dependent

☐ Delta Dental of PA
☐ Inter-County Hospitalization/Health Plan, Inc.

*** Please return all copies intact.**

SHADED AREA FOR OFFICE USE ONLY	GROUP #:	EFFECTIVE DATE:	PROCESSED BY:	DATE:

Employee Name:______________________________ Phone:____________________

Full Address:____

Date of Full-Time Employment: _____/_____/______

	RELATIONSHIP	SEX M/F	DATE OF BIRTH	SOCIAL SECURITY	HEIGHT FT - IN	WEIGHT
INFORMATION ON EMPLOYEE TO BE INSURED: →						
DEPENDENTS TO BE INSURED: (last name if different)						
1)						
2)						
3)						
4)						

Employer: __________________________ Are you covered by Workers' Compensation: Yes No

Job Title/Duties: ________________________ Insurance Class: __________________

Are you working your regular work week with this employer: **Yes:** Weekly Hours: ________ Earnings: $________ Annual Weekly Hourly
No - Reason: COBRA Retired Disabled Other

Marital Status: Single Marrried Widowed Divorced Legally Separated

Medical History Declaration: In the past seven years, have you or any listed dependent received or been advised to receive or seek in the future advice, consultation, examination, surgery, treatment or medication for any medical condition by any physician, or other licensed medical care practitioner, hospital or medical facility?

Yes No **For any "Yes" answer(s) list complete details of condition/treatment/medication(s) in the chart provided below.**

a. For high blood pressure*, chest pain, heart trouble, stroke or other circulatory problem;
b. For cancer, diabetes**, sugar/blood in urine, kidney/bladder disease, gynecological or disorder of reproductive organs; arthritis, back trouble, neurological/muscular/skeletal disorder, lung/respiratory condition, or digestive or glandular disorder;
c. For Acquired Immune Deficiency Syndrome (AIDS), Aids Related Complex (ARC) or other immune system disorder;
d. For mental, emotional, or nervous disorder, substance, drug or alcohol abuse or disease;
e. For current disability, pregnancy or complications thereof, or are you currently pregnant;
f. For any medical care or prescription medication [including mail order maintenance drug(s)] not listed above.

Question Letter	Person's Name (Applicant)	Condition(s)/Treatment/Medication(s) *Blood Pressure Reading **Fasting Blood Sugar Reading	Onset Date	Operation Date Mo./Yr. Days in Hospital	Recovery Date	Prognosis	Name, Address & Phone # of all Physicians & Hospitals

Waiver of Medical Declaration: Group pre-approved through pre-underwriting.

BENEFIT ELECTION, SIGNATURE AND DATE MUST BE COMPLETED ON ALL PAGES.

BENEFIT ELECTION	MEDICAL	SUPP PLAN	RX DRUG	VISION	LIFE AD&D	DEPENDENT LIFE	STD	LTD	DELTA DENTAL
SELF						N/A			
SPOUSE					N/A		N/A	N/A	
DEPENDENTS					N/A		N/A	N/A	

Harleysville Life Insurance Company Only
Amounts Requested (subject to Group Master Application)
Life/AD&D $______ Dependent Life _______ # of Units
Beneficiary____________________
Short Term DIS $_______/Wk. Long Term DIS $_______/Mo.

Complete if your spouse or dependents have other insurance.

	other health carrier plan	other dental carrier plan
Spouse:		
Dependents:		

Complete if Medicare Coverage. **(attach copy of cards)**

ID #______________
Part A Effective Date ___/___/___
Part B Effective Date ___/___/___

If Applicable: Spouse's Employer: ________________________ Work Phone #: (______)____________
Were you or your dependents insured for comparable coverage with this employer's former health plan prior to being eligible for this coverage? Yes No
Dates of continous health coverage prior to this plan: _____/_____/_____to_____/_____/_____ [attach certification(s)] Insurer(s): ________________

To Request Coverages (Please read and sign below.)

I am requesting the coverage(s) selected above under the group policy(ies) issued by the insurer. I authorize any licensed physician, medical practitioner, hospital, medically related facility, utilization management or peer review organization, or any insurance company institution or person having any records or knowledge of myself, my health, and/or my dependents and their health to give such information to the insurer, its reinsurers or their representatives. A photocopy of this authorization shall be as valid as the original.

Conditions of Enrollment - I represent that all information supplied on this form is true and complete to the best of my knowledge and belief. I acknowledge and agree to the Conditions of Enrollment and the Consumer Notice(s) on the reverse side of this application.

Employer's Initials ________ **Employee's Signature** ________________________ **Date**____/____/____

To Decline Coverages (Please read and sign below.)

I understand that I am eligible for benefits under the group health insurance plan(s) for employees of the employer named above. Benefits under such plan(s) have been explained to me in detail. After careful consideration, I decline coverage(s) not selected above for myself and/or my eligible dependents and waive all claims to benefits under any of the plan(s).

Reason:
Election of HMO coverage provided by my employer
Coverage through my spouse's employer
Declined for contributory benefits (employee pays portion of premium)
Other reason ______________

I hereby acknowledge the Health Insurance Portability & Accountability Act (HIPAA) Notice on the reverse side of this application.

Employer's Initials ________ **Employee's Signature** ________________________ **Date**____/____/____

CONDITIONS OF ENROLLMENT

- I understand that the Group Master Application and Master Group Contract will determine the rights and responsibilities of insured(s) and the insurer and will govern in the event of conflict with other materials provided by my employer or the insurer.
- I understand that it is my responsibility to report to my employer any changes in the eligibility of myself or the individuals listed or any change to the information provided on this application.
- I understand that enrollment is not effective until acceptance by the insurer in writing, and any insurance shall be binding only if statements made by me to induce acceptance of this application are complete and true to the best of my knowledge and belief.
- I understand that if I am absent from work at the time my insurance would otherwise become effective, my coverage may not become effective until I return to work.
- I understand the coverage and benefits are contingent upon prompt payment of premiums.
- I understand that any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and subjects such person to criminal and civil penalties and may result in termination of benefits.
- I understand that omissions or misstatements in answering the questions on this application or nonpayment of premiums may cause claims to be denied and coverage terminated.
- I authorize my employer to deduct any required contribution for the insurance coverage from my earnings.
- I understand that the effective date of coverage for myself and my eligible dependents shall be determined according to the guidelines established by the insurer and the Master Group Contract.
- I am employed by the employer named on this application, and I am working for this employer at least thirty hours per week.
- I understand that this application will be processed through my employer and the third party administrator and that all statements made on this application and action regarding it will be available to my employer, the third party administrator, the insurer and its reinsurers and representatives, and any other party involved in processing this application.
- I understand that benefits, limits and other coverage provisions shall be as outlined in the Master Group Contract.
- I understand that limitations on pre-existing conditions may apply under the medical plan. I further understand that a pre-existing condition is a condition for which medical advice, diagnosis, care or treatment has been recommended or received within the 90-day period ending on the first day of coverage under the Master Group Contract or, if there is a waiting period, the first day of the waiting period. Payments for pre-existing conditions will be limited to a certain dollar amount. Limits for pre-existing conditions apply for the 12 month period starting on the first day of coverage or, if there is a waiting period, the first day of the waiting period. I understand that I have the right to reduce or eliminate any pre-existing condition limitation by demonstrating creditable coverage, which includes coverage under a group health plan, individual health insurance coverage, Medicare and certain other coverages. I have the right to request a certificate of creditable coverage from a prior plan, and I understand that the insurer will assist me in obtaining a certificate if necessary. I further understand that the limitation period may be reduced by the total of any periods of creditable coverage as of the effective date of coverage, provided there is not a 63-day or more break in coverage.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) NOTICE

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.

CONSUMER NOTICE

If any investigation is conducted in connection with your application, you are entitiled, under the Federal Fair Credit Reporting Act, to disclosure of the nature and scope of that investigation. If a consumer investigative report is prepared, you may obtain a copy of such report. Further information regarding the investigation and any investigative consumer reports may be obtained by mailing your request to:

404 Baltimore Street
P.O. Box 1060
Gettysburg, PA 17325-1060

The type of information the insurer may obtain includes any which relates to your mental and physical health, character and general reputation, habits, finances, occupation, income, insurance coverage, and participation in aviation and other hazardous activites.

If insurance is sought for members of your family, similar information may be requested about them. The insurer may also obtain information from your friends, neighbors, associates and past and present employers, either directly or through an investigative consumer report. Information obtained by an insurance-support organization may be retained by it and disclosed to other persons as permitted by the Federal Fair Credit Reporting Act and other applicable laws.