ASPIRANT

GROUP HEALTH PLANS – EMPLOYEE APPLICATION/WAIVER
ASBURY UNIVERSITY

☐ **NEW ENROLLMENT** ☐ **CHANGE ENROLLMENT**

A. EMPLOYEE INFORMATION

LAST NAME | FIRST NAME | MI

PARTICIPANT SSN ___ - ___ - ___ PARTICIPANT DOB ___ / ___ / ___

ADDRESS | CITY | STATE

ZIP CODE

COVERAGE TYPE: ☐ MEDICAL - CORE ☐ MEDICAL - BUYUP

GENDER: ☐ MALE ☐ FEMALE MARITAL STATUS: ☐ MARRIED ☐ SINGLE

HIRE DATE: ___ / ___ / ___ EFFECTIVE DATE: _____

TERMINATION DATE: _____

B. COVERAGE YOU ARE REQUESTING

☐ EMPLOYEE ONLY ☐ EMPLOYEE & SPOUSE ☐ EMPLOYEE & CHILD(REN) ☐ EMPLOYEE & FAMILY

IF ENROLLMENT CHANGE PROVIDE QUALIFYING EVENT _____

C. FAMILY INFORMATION – ENROLLMENT

SPOUSE: LAST NAME | FIRST NAME | MI

SPOUSE SSN: ___ - ___ - ___ SPOUSE DOB: ___ / ___ / ___

GENDER: ☐ MALE ☐ FEMALE

CHILD: LAST NAME | FIRST NAME | MI

CHILD SSN: ___ - ___ - ___ CHILD DOB: ___ / ___ / ___

GENDER: ☐ MALE ☐ FEMALE

CHILD: LAST NAME | FIRST NAME | MI

CHILD SSN: ___ - ___ - ___ CHILD DOB: ___ / ___ / ___

GENDER: ☐ MALE ☐ FEMALE

CHILD: LAST NAME | FIRST NAME | MI

CHILD SSN: ___ - ___ - ___ CHILD DOB: ___ / ___ / ___

GENDER: ☐ MALE ☐ FEMALE

Are you or any of your Dependents covered by **Medicare**? ☐ Yes ☐ No If yes, complete the information on the right.	Name	Reason	Covered By:	Dates Became Effective	Medicare Numbers
		☐ Over 65 ☐ Disabled ☐ End Stage Renal Disease	☐ Part A ☐ Part B ☐ Part C ☐ Part D	A. ___/___/___ B. ___/___/___ C. ___/___/___ D. ___/___/___	A. _____ B. _____ C. _____ D. _____
	Name	Reason	Covered By:	Dates Became Effective	Medicare Numbers
		☐ Over 65 ☐ Disabled ☐ End Stage Renal Disease	☐ Part A ☐ Part B ☐ Part C ☐ Part D	A. ___/___/___ B. ___/___/___ C. ___/___/___ D. ___/___/___	A. _____ B. _____ C. _____ D. _____

D. PRIOR MEDICAL COVERAGE

1. ARE YOU OR ANY OF YOUR DEPENDENTS INSURED THROUGH ANY OTHER HEALTH INSURANCE PLAN WHILE COVERED UNDER THIS PLAN?
☐ **YES** ☐ **NO** **IF YES**, PLEASE COMPLETETHE FOLLOWING REQUIREMENTS:

2. HEALTH INSURANCE COMPANY		TELEPHONE NO.	
POLICY OR CERTIFICATE NO.		EFFECTIVE DATE	
COVERAGE TYPE	☐ INDIVIDUAL ☐ EMPLOYER SPONSORED	TERMINATION DATE	
LIST ALL COVERED MEMBERES		POLICY HOLDER NAME	

Premium Payment: I authorize my employer to deduct the requested premium contribution from my earnings.

Authorization to Release Information: I hereby authorize any physician or medical practitioner, hospital, or other organization, institution or person that has any medical records or knowledge of me or my family as to diagnosis, treatment and prognosis regarding any physical, mental, drug or alcohol condition or any and all such information to be given to Aspirant or its authorized Administrator or legal representative (including medical review specialists). Any information obtained will not be released by the insurance company except to persons or organizations performing business or legal services in connection with my application or claim, including but not limited to pre-certification of hospital admissions, Continued Stay Review, On-Site Concurrent Review or as may be otherwise lawfully required or as I further authorize. A photocopy of this authorization shall be valid as the original and is valid for thirty (30) months from the date shown below.

U.S. Resident: I understand that the coverage under this plan is available for United States Residents and benefits are not payable for medical expenses outside of the United States except while traveling.

My Answers Are True and Correct: I have personally reviewed all of my answers to the questions on this application and represent that all of the information I have provided is true and complete. I understand that it is my responsibility to provide truthful, complete and accurate information and I represent I have fully understood all the questions asked. With the exception of health-related factors, I understand that my intentional material misstatements or failure to report information may be used as the basis of rescission or termination of coverage for me or my dependents, if any. I understand that under no circumstances is any agent allowed to (a) waive, alter or modify any questions; (b) permit me to inaccurately answer any questions; or (c) instruct me not to disclose any particular medical condition on the application. I understand that no agent is authorized or has authority to alter the terms of the Group Master Policy.

☐ **WAIVER OF COVERAGE.** This is to certify that I have been given an opportunity to insure myself and/or my eligible dependents and I have DECLINED such coverage. I understand that if I am declining enrollment for myself or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself and my dependents in this plan, provided that I request enrollment within thirty-one (31) days of my other coverage ending. In addition, if I have a new dependent as a result of marriage, birth, adoption, party in a suit in which the adoption of child by me is sought or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within thirty-one (31) days after the marriage, birth, adoption, party in a suit in which the adoption of child by me is sought or placement for adoption. If I choose to enroll myself or my dependents, at a later date, for a reason other than the special reasons stated herein, I understand that I and/or my dependents may not enroll until my employer's next enrollment period.

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is subject to civil and criminal penalties.

E. SIGNATURE

Phone Number: _____ Email Address: _____

_____ Date: _____

Signature of Employee and Parent if Applicant is under the age of eighteen (18) years

SUBMIT