PACIFIC UNION COLLEGE
GROUP ENROLLMENT FORM / CHANGE FORM

☐ NEW ENROLLEE ☐ CHANGE IN CURRENT STATUS ☐ SPECIAL ENROLLMENT: SPECIAL EVENT_____
☐ ANNUAL ENROLLMENT DATE OF SPECIAL EVENT_____

DO YOU HAVE A CERTIFICATE OF COVERAGE (IF BLANK, THE PLAN WILL ASSUME "NO") ☐ YES (IF YES, PLEASE ATTACH) ☐ NO

THIS AREA TO BE COMPLETED BY EMPLOYER

GROUP #	LOCATION #
117433	
DATE OF HIRE	COV EFF. DATE
DEPARTMENT	☐ PD ☐ FD ☐ PV ☐ FV

YOUR NAME (Please Print) _____
Last First Middle Initial

ADDRESS _____
Street / Apt #

ADDRESS _____
City State Zip Code

Phone- Home Cell e-mail

☐ MALE ☐ FEMALE
GENDER

_____ / _____ / _____
Mo. Day Year
DATE OF BIRTH

___ ___ ___ / ___ ___ / ___ ___ ___ ___
SOCIAL SECURITY NUMBER

☐ SINGLE ☐ WIDOWED
☐ MARRIED ☐ DIVORCED

COVERAGE (Check only those that apply)

MEDICALTIER: ☐ SINGLE ☐ EMP + 1 ☐ EMP + 2 or more
DENTAL TIER: ☐ SINGLE ☐ EMP + 1 ☐ EMP + 2 or more
VISION TIER: ☐ SINGLE ☐ EMP + 1 ☐ EMP + 2 or more

PLAN OPTION:
☐ PPO ☐ HDHP

DEPENDENT INFORMATION (Complete if you elected family Coverage)

DEPENDENT	M	F	FIRST	MIDDLE INT.	LAST	SSN#	DATE OF BIRTH MONTH DAY YEAR
SPOUSE	☐	☐					
CHILD	☐	☐					
CHILD	☐	☐					
CHILD	☐	☐					
CHILD	☐	☐					

IF YOUR SPOUSE OR CHILDREN HAVE A LAST NAME DIFFERENT FROM YOURS, PLEASE PROVIDE A MARRIAGE LICENSE AND/OR BIRTH CERTIFICATE.
IF YOUR DEPENDENT CHILD IS 26 OR OLDER, PLEASE PROVIDE DISABILITY VERIFICATION. DATE OF MARRIAGE: _____ / _____ / _____

OTHER INSURANCE

ARE YOU/ANY OF YOUR DEPENDENTS COVERED BY ANOTHER GROUP MEDICAL PLAN? ☐ YES ☐ NO IF YES, EFFECTIVE DATE OF COVERAGE _____ / _____ / _____

NAME OF PRIMARY INSURED / POLICY HOLDER _____ DATE OF BIRTH OF POLICY HOLDER _____ / _____ / _____

NAME OF COVERED DEPENDENT(S) _____

ID NUMBER_____ NAME OF INSURANCE CARRIER OR TPA_____

ADDRESS _____ PHONE _____

NAME OF OTHER EMPLOYER PROVIDING COVERAGE _____ IS MEDICARE/MEDICAID APPLICABLE? ☐ YES ☐ NO

IS YOUR SPOUSE EMPLOYED? ☐ YES ☐ NO IF YES, IS SPOUSE ELIGIBLE FOR INSURANCE THROUGH EMPLOYER NOW OR IN THE FUTURE? ☐ YES ☐ NO

PROVIDE DETAILS _____

IF SPOUSE IS EMPLOYED WITH NO OTHER INSURANCE, PLEASE PROVIDE MONTHLY SALARY $_____

IS THERE A DIVORCE DECREE OR COURT ORDER REQUIRING YOU TO BE FINANCIALLY RESPONSIBLE FOR MEDICAL COVERAGE FOR DEPENDENT CHILDREN?

☐ YES ☐ NO IF YES, PROVIDE COPY

WHO HAS PRIMARY CUSTODY OF COVERED CHILDREN? ☐ MOTHER ☐ FATHER

BENEFIT WAIVER STATEMENT

I THE UNDERSIGNED CERTIFY THAT I HAVE BEEN GIVEN AN OPPORTUNITY TO APPLY FOR THE GROUP BENEFIT PLAN OFFERED BY THE COMPANY AND AFTER CAREFUL CONSIDERATION HAVE DECIDED TO DECLINE TO ENROLL IN THE COVERAGE HEREAFTER INDICATED.

DECLINE: ☐ MEDICAL ☐ DENTAL ☐ VISION

ARE YOU DECLINING DUE TO COVERAGE IN ANOTHER PLAN? ☐ YES ☐ NO (IF BLANK, THE PLAN WILL ASSUME "NO")
IF YES, IS THIS OTHER COVERAGE COBRA? ☐ YES ☐ NO

☐ OTHER (PLEASE EXPLAIN) _____

IMPORTANT NOTICE: If you refuse coverage for yourself, you automatically refuse coverage for any dependents. 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. Also, you must indicate the reason for declining enrollment to later be eligible under the special enrollment rules. 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, provide that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. The pre-existing condition limitation is stated in the summary plan description. You and/or your dependents have the right to demonstrate creditable coverage by requesting a certificate of coverage from your prior plan or insurer. If necessary and requested, the plan will assist you in obtaining the certificate. I have received and read a summary of the plan description, and any amendments regarding the impact of HIPAA. I certify that the above information is true and accurate.

SIGNATURE OF EMPLOYEE _____ DATE SIGNED _____

**********PLEASE SEE NEXT PAGE FOR FINAL SIGNATURE**********

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DATE AND SIGN ENROLLMENT FORM ELECTIONS

Condition of Enrollment (To be completed by all employees)

I understand that:

- Coverage does not become effective until this application has been approved by the applicable insurance company, third party administrator or Pacific Union College.
- I am responsible for a greater portion of my health care costs when I use a non-participating provider, if applicable.
- California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.
- Collection of social security numbers for myself and my dependents will be used by the applicable insurance company, third party administrator and my Company only as allowed by law.

I am aware that:

I have 30 days from my date of hire or change in status to enroll in the benefits programs at Pacific Union College. I further understand my option to change my dependent status is available only at Open Enrollment or when a change in family status or similar event occurs. If I waive dental and/or vision coverage now that when I re-enroll I will only be eligible to receive preventive benefits for the first 12 months after re-enrollment.

I agree that:

All information on this form is correct and true to the best of my knowledge and belief. This information is the basis on which coverage may be issued under the plans. If I have misrepresented or omitted any material fact that my coverage may be cancelled or my employer's contract rescinded. Any person who, with intent to defraud or knowingly is facilitating a fraud against an insurer, submits an application or files a claim with false or deceptive statements, may be guilty of insurance fraud.

I further authorize my employer to deduct from my earnings any required contribution.

I, the applicant, acknowledge that I have read and understood this Enrollment/Waiver form in its entirety.

I certify that all information and statements on this enrollment form are true and complete to the best of my knowledge and that I have authority to make statements on behalf of any dependents listed on this form. I am employed by Pacific Union College and working full-time for Pacific Union College.

SIGNATURE OF EMPLOYEE _____

DATE SIGNED _____

If contributions are required for any of the above coverage, I authorize the Company to deduct from my earnings the applicable contribution(s) for the coverage hereafter listed (if none, please indicate.)