ENROLLMENT ELECTION FORM

TPA OF GEORGIA

PO Box 2639 • Lilburn, GA 30048 • 770-451-7550

Company Name	
Name *(Last, First, MI)*	COMPANY USE ONLY
Address	Hire Date
City, State, Zip	Effective Date
Telephone	Division
E-Mail	Location
Date Of Birth	

◯ Male ◯ Female	◯ Single ◯ Married ◯ Divorced ◯ Widowed
◯ Annual Enrollment	◯ New Hire ◯ Revision ◯ Full Time ◯ Part Time

◯ **YES, I ELECT MEDICAL COVERAGE** *Complete dependent coverage below*	◯ Single ◯ Family	Monthly Cost
◯ **YES, I ELECT DENTAL COVERAGE** *Complete dependent coverage below*	◯ Single ◯ Family	Monthly Cost

DEPENDENT CHANGE *Complete dependent coverage below* **Supporting documentation required.*

◯ Add Dependent ——	◯ Birth	◯ Adoption*	◯ Marriage*	◯ Student Verification*	◯ Other *:	
◯ Cancel Dependent ——	◯ Death	◯ Retirement	◯ Divorce*	◯ Loss of Eligibility	◯ Other *:	

MEDICAL AND/OR DENTAL COVERAGE

List eligible family members to be covered. Include your spouse and unmarried children under age 19 (or 23 if a full-time student). A copy of the court order must be attaced for dependents in court-ordered custody or guardianship of the certificate holder. Please print.

	First Name	M I	Last Name *(if different)*	Birthdate	
Spouse ◯ Male ◯ Female					◯ Living with you ◯ FT Student ◯ PT Student ◯ Disabled
Child ◯ Male ◯ Female					◯ Living with you ◯ FT Student ◯ PT Student ◯ Disabled
Child ◯ Male ◯ Female					◯ Living with you ◯ FT Student ◯ PT Student ◯ Disabled
Child ◯ Male ◯ Female					◯ Living with you ◯ FT Student ◯ PT Student ◯ Disabled
Child ◯ Male ◯ Female					◯ Living with you ◯ FT Student ◯ PT Student ◯ Disabled

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LIFE INSURANCE AND AD&D

See your HR Administrator for information on Life Insurance and AD&D

List primary Life Insurance beneficiary(s)

First Name	M I	Last Name	Social Security Number	Relation To You	% Share	Address

OTHER CARRIER LIABILITY INFORMATION

Are you or any member of your family covered by any other health plan? ◯ No ◯ Yes
If yes, complet the appropriate section(s) below. If more space is required, attach separate sheet with additional information.

HEALTH		ADD'L HEALTH OR DENTAL		MEDICARE	
Insured's/Member's Name	DOB	Insured's/Member's Name	DOB	Beneficiary Name	
◯ Actively Employed ◯ Retired		◯ Actively Employed ◯ Retired		Entitlement Reason: ◯ Age 65 or Older	
Name of Employer		Name of Employer		◯ End Stage Renal Disease ◯ Other Disability	
Policy Number		Policy Number		Medicare HIC #	
Effective Date ◯ Family Coverage ◯ Single Coverage		Effective Date ◯ Family Coverage ◯ Single Coverage		Part A Effect Date	Part B Effect Date
Name of Insurance Company	Phone	Name of Insurance Company	Phone	Beneficiary Name	
Claims Center City, ST, Zip Code		Claims Center City, ST, Zip Code		Entitlement Reason: ◯ Age 65 or Older	
Does the above insurance cover "all" members including yourself? ◯ Yes ◯ No		Does the above insurance cover "all" members including yourself? ◯ Yes ◯ No		◯ End Stage Renal Disease ◯ Other Disability	
If no, list all dependents not covered:		*If no, list all dependents not covered:*		Medicare HIC #	
				Part A Effect Date	Part B Effect Date

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EMPLOYEE AUTHORIZATION AND CERTIFICATION

1. I understand that my share of the cost of the coverage which I have elected will be contributed on a pre-tax basis for the Medical and/or Dental Plan. For all other coverages I have elected, my share of the cost will be deducted on an after-tax basis. I authorize my employer to make the corresponding deductions/reductions in my paycheck.
2. I understand that I may not change my pre-tax elections until the next annual enrollment except in the case of an approved Change in Family Status.
3. I understand that if I name more than one beneficiary, the death benefit will be divided equally between the named beneficiaries who survive me. If none survive me, payment will be made in accordance with the terms of the applicable plan.
4. I understand that my beneficiary elections made currently on this form supersede my previous beneficiary designations I may have given for the same insurance coverage.
5. Upon presentation of the original or photocopy of this signed authorization, I authorize any Physician, Medical Practitioner, Hospital, Clinic, Prescription Drug company, medical or medically related facility, insurance or reinsurance company, medical information bureau, third party administrator or any other entity having information available as to the diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my dependents and any other non-medical information about me or my dependents to give any and all such information to my employer, third party administrator, plan administrator, managed care entity or an entity administering a disease state management program for the purpose of identification, outreach and/or solicitation of me or my dependents regarding participation in particular programs designed to manage and facilitate the treatment of a particular physical or mental condition.
6. I understand that my employer retains the right to terminate or modify the benefit plans at any time.
7. I also authorize the use of a social security number for purpose of identification.
8. I understand that this health plan may contain a provision which excludes coverage for pre-existing conditions.

Signature of Applicant/Employee	Date

REFUSAL OF ANY/ALL COVERAGE/MEMBERSHIP

I decline to apply for coverage/membership for myself and my dependent(s). I understand that, if I decide to apply at a later time, that coverage/membership may not be available until the next open enrollment period, or I may be required to provide evidence of insurability.

◯ Medical ◯ Dental ◯ Suplemental Life ◯ Dependent Life ◯ Short Term ◯ Other:

Signature of Applicant/Employee	Date