

Employee Enrollment Form

<input type="radio"/> New Enrollment <input type="radio"/> Late Enrollment (Statement of Health required)					
A. Employee Information (Complete for ALL Enrollments)					
Employer Name/Company Name (Please Print)		Division	Group ID	County	State
Last Name		First Name	MI	Social Security Number	
Address		City	State	Zip	Date of Birth
<input type="radio"/> Male <input type="radio"/> Female	Marital Status: <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Single <input type="radio"/> Widowed	Spouse's Date of Birth	Home Phone	Work Phone	
Completed By Employer					
Effective Date:		Date of Full-Time Employment:		Occupation:	
Earnings: \$ _____		<input type="radio"/> Hourly <input type="radio"/> Weekly <input type="radio"/> Monthly <input type="radio"/> Yearly	Hours Worked Per Week:		
B. Product Selection (Complete for ALL Enrollments)					
CORE PLAN EMPLOYER PAID (Indicate employee-paid optional buy-up amounts below.)					
Check circle(s) for all coverages you are applying for. All coverage amounts are subject to limitations and exclusions as stated in the policy.*					
Type of Coverage	Yes/No		Amount of Coverage	Premium	
Employer Paid Life	<input type="radio"/> Yes <input type="radio"/> No		\$20,000		
Employer Paid Short Term Disability	<input type="radio"/> Yes <input type="radio"/> No		\$100		
Employer Paid Long Term Disability	<input type="radio"/> Yes <input type="radio"/> No		\$500		
<input type="radio"/> VOLUNTARY PLAN (Indicate total maximum benefit amounts below.) OR <input type="radio"/> OPTIONAL BUY-UPS FOR CORE PLAN (Employee must buy-up to elect spouse and/or dependent coverage.)					
Check circle(s) for all coverages you are applying for. All coverage amounts are subject to limitations and exclusions as stated in the policy.					
Type of Coverage	Yes/No		Amount of Coverage	Premium	
Employee Life Underwritten by The Lincoln National Life Insurance Company	<input type="radio"/> Yes <input type="radio"/> No		<input type="radio"/> \$20,000 <input type="radio"/> \$40,000 <input type="radio"/> \$60,000 <input type="radio"/> \$80,000 <input type="radio"/> \$100,000 <input type="radio"/> \$120,000 (50+ Life Groups) <input type="radio"/> \$140,000 (50+ Life Groups) <input type="radio"/> \$160,000 (50+ Life Groups)		
Spouse Life Underwritten by The Lincoln National Life Insurance Company Spouse amt not to exceed 50% of employee amt. Groups of 5-49 lives, Evidence of Insurability is required for \$30,000-\$50,000 coverage levels	<input type="radio"/> Yes <input type="radio"/> No		<input type="radio"/> \$10,000 <input type="radio"/> \$20,000 <input type="radio"/> \$30,000 (50+ Life Groups) <input type="radio"/> \$40,000 (50+ Life Groups) <input type="radio"/> \$50,000 (50+ Life Groups)		
Dependent Life Child Benefit Underwritten by The Lincoln National Life Insurance Company	<input type="radio"/> Yes <input type="radio"/> No		<input type="radio"/> \$10,000		
Short Term Disability Underwritten by The Lincoln National Life Insurance Company Weekly Ben. amt not to exceed 60% weekly pay Weekly Benefit amt: \$100 min/\$1000 max. Bought up in increments of \$50.	<input type="radio"/> Yes <input type="radio"/> No		Weekly Benefit Amount:\$ Amount \$ _____ Minimum purchase amount \$100		
Long Term Disability Underwritten by The Lincoln National Life Insurance Company Mo. Ben. amt not to exceed 60% base mo. pay Monthly Ben. amt: \$500 min/\$6000 max. Bought up in increments of \$100.	<input type="radio"/> Yes <input type="radio"/> No		Monthly Benefit Amount:\$ Amount \$ _____ Minimum purchase amount \$500		



Employer Plan Services Inc
 PO Box 2727, Houston, TX 77252
 p. 800.207.9224 f. 713.369.0703

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Dental Underwritten by United HealthCare Insurance Company Inc	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Employee <input type="radio"/> Employee/Spouse <input type="radio"/> Employee/Child <input type="radio"/> Family	
Vision Underwritten by OptumHealth Specialty Benefits	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Employee <input type="radio"/> Employee/Spouse <input type="radio"/> Employee/Child <input type="radio"/> Family	

C. Dependent and Other Insurance Information

	Last Name	First Name	MI	Sex	Birth Date
Spouse					
Child(ren)					

D. Beneficiary Information (Complete ONLY for Life Enrollments) **Employer to File**

Primary Beneficiary's Last Name	First	MI	Relationship	Social Security Number	
Street Address		City		State	Zip
Contingent Beneficiary's Last Name	First	MI	Relationship	Social Security Number	
Street Address		City		State	Zip

Note: A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you. If you wish to designate more than one Contingent Beneficiary, please attach a separate sheet of paper.

E. Signature (Complete for ALL Enrollments)

Signature Section:

I understand that by selecting "no", if I desire to participate in the Program at some future date, my coverage or my dependents' coverage will not be effective until after Evidence of Insurability is submitted and approved. I understand if a physical examination or further medical information is required, it will be at my own expense.

I hereby apply for group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary. I reserve the right to revoke this deduction at any time on written notice.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Employee Signature

Date Signed

STATE REQUIRED FRAUD NOTICES

CALIFORNIA

NOTICE: CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.

COLORADO

NOTICE: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY SERVICES.

DISTRICT OF COLUMBIA

IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

FLORIDA

NOTICE: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER, FILES A STATEMENT OF CLAIM, OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

KENTUCKY

NOTICE: ANY PERSON WHO KNOWINGLY AND WITH THE INTENT TO DEFRAUD AN INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

LOUISIANA

NOTICE: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MARYLAND

ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULANT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NEW JERSEY

NOTICE: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NEW MEXICO

NOTICE: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NEW YORK

ACCIDENT & HEALTH INSURANCE FRAUD: Any person who knowingly and with intent to defraud any insurance company or other person:

(1) files an application for insurance or a statement of claim containing any materially false information; or

(2) conceals, for the purpose of misleading, information concerning any fact material thereto;

commits a fraudulent insurance act, which is a crime. Such person shall also be subject to a civil penalty not to exceed \$5000 and the stated value of the claim for each violation.

OHIO

NOTICE: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

PENNSYLVANIA

NOTICE: 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 OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL CIVIL PENALTIES.

TENNESSEE and WASHINGTON

NOTICE: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.

FOR ALL OTHER STATES EXCLUDING CONNECTICUT, KANSAS, AND VIRGINIA

NOTICE: A PERSON MAY BE COMMITTING INSURANCE FRAUD, IF HE OR SHE SUBMITS AN APPLICATION OR CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT WITH INTENT TO DEFRAUD (OR KNOWING THAT HE OR SHE IS HELPING TO DEFRAUD) AN INSURANCE COMPANY.