

ENROLLMENT FORM 2023



Employer Information

Employer Name A-1 Personnel of Houston. Inc.	Group Number FCR8619	Date of Hire	Effective Date
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Employee Information

Last Name	First Name	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security #
Date of Birth	Salary	Occupation Client Assignment <input type="checkbox"/> City of Houston <input type="checkbox"/> Harris County <input type="checkbox"/> _____	
Address	City	State	Zip
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Separated	Email Address	Phone Number	Reason for Enrollment <input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire <input type="checkbox"/> Family Status

Medical Coverage Options

<input type="checkbox"/> Minimum Essential Coverage (MEC) Plan <input type="checkbox"/> MEC Plus Value Plan <input type="checkbox"/> MEC Plus Select Plan <input type="checkbox"/> Minimum Value Plan (MVP) - (must complete IHQ form to enroll in MVP) <input type="checkbox"/> Waive Coverage	Choose One Option Only	Coverage Tier <input type="checkbox"/> Employee <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Family
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Life and/or AD&D Insurance Beneficiary Designation

Beneficiary Name	Date of Birth	Relationship
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Dependent Information

Last Name	First Name	Gender	Social Security #	Date of Birth
Spouse		<input type="checkbox"/> Male <input type="checkbox"/> Female		
Dependent		<input type="checkbox"/> Male <input type="checkbox"/> Female		
Dependent		<input type="checkbox"/> Male <input type="checkbox"/> Female		
Dependent		<input type="checkbox"/> Male <input type="checkbox"/> Female		

Current/Prior Coverage

Have you or your dependents been covered under this employer's plan or any other major medical plan(s) at any time in the past 12 months? Yes No

If yes, who is covered? <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)	Name of Carrier	Policy/ID#	Effective Date
Will prior coverage remain active when coverage under this employer's plan goes into effect? <input type="checkbox"/> Yes <input type="checkbox"/> No			If no, what is the term date?

Qualified Medical Child Support Order

Are any of your dependents covered by a Qualified Medical Child Support Order? Yes No (if yes, complete below)

Custodial Parent	Name of Dependent	Dependent's Social Security #	Dependent's Date of Birth	
Dependent's Residential Address		City	State	Zip

Waiver of Coverage

I elect to waive coverage for myself? Yes Reason:

I elect to waive coverage for my dependents? Yes Reason:

Name(s) of Dependent(s) for which to waive coverage:

Signature

Date

Employee Agreement

I hereby apply for participation in my employer's Employee Health and Welfare Benefit Plan for myself and/or my dependents listed above and agree to abide by the terms, provisions, and limitations as outlined by the Plan Sponsor in the issuance of the Plan Summary Description. I declare all statements contained in this form are true and correct and that no material information has been withheld or omitted. I understand that any misstatements or failure to report information that is material to my qualification and participation may be used as a basis for rescission of my participation and/or denial of payment of claims. I agree no benefits will be effective until the date specified at the top of this form.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, the Veterans Administration, the Medical Information Bureau (MIB), or any other organization, institution, insurance or reinsurance company, to disclose and release any information in its possession about the medical history, mental or physical condition or treatments of myself and/or my dependents to Fringe Benefit Group or its designee. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Signature

Date