# ~~ENROLLMENT FORM~~ 2023 Waiver Form

## Employer Information

| Employer Name | Group Number | Date of Hire | ~~Effective Date~~ |
|---|---|---|---|
| A-1 Personnel of Houston, Inc. | FCR8619 | | |

## Employee Information

| Last Name | First Name | Gender | Social Security # |
|---|---|---|---|
| | | ☐ Male ☐ Female | |
| **Date of Birth** | **~~Salary~~** | **~~Occupation~~** | |
| **Address** | **City** | **State** | **Zip** |
| | | | |

| Marital Status | Email Address | Phone Number | Reason for Enrollment |
|---|---|---|---|
| ☐ Single ☐ Divorced ☐ Married ☐ Separated | | | ☐ Open Enrollment ☐ New Hire ☐ Family Status |

## Medical Coverage Options

☐ Minimum Essential Coverage (MEC) Plan
☐ MEC Plus Value Plan
☐ MEC Plus Select Plan
☐ Minimum Value Plan (MVP) - (must complete IHQ form to enroll in MVP)
☐ Waive Coverage

**Coverage Tier**
☐ Employee
☐ Employee + Spouse
☐ Employee + Child(ren)
☐ Family

## Life and/or AD&D Insurance Beneficiary Designation

| Beneficiary Name | Date of Birth | Relationship |
|---|---|---|
| | | |

## Dependent Information

| Last Name | First Name | Gender | Social Security # | Date of Birth |
|---|---|---|---|---|
| Spouse | | ☐ Male ☐ Female | | |
| Dependent | | ☐ Male ☐ Female | | |
| Dependent | | ☐ Male ☐ Female | | |
| Dependent | | ☐ Male ☐ Female | | |

Fringe Benefit Group (888) 798-9480

## 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** | **Name of Co** | **P /ID#** | **Eff e Date** |
|---|---|---|---|
| ☐ Employee ☐ Spou<br>☐ Child(ren) | | | |

| **Will prior coverage remain ac coverage under this employer's plan goes into e** | **If no, what is the term date?** |
|---|---|
| ☐ Yes ☐ No | |

## Qualified Medical Child Support Order

**Are any of your depende overed by alified Medical Child Support Order?** ☐ Yes ☐ (If yes, complete below)

| **Custodial Parent** | **Name of De dent** | **Dependent's So ecurity #** | **Dep ent'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 cipation in my employe ployee Health and Welf enefit Plan for myself a my dependents listed above and ag abide by the ter ovisions, and limitations as out by the Plan Spons he issuance of the Plan Summary Descripti declare all st ents contained in this form are true correct and t o material information has been withheld or omit understo that any misstatements or failure to repo rmatio is material to my qualification and participati sed as a basis for rescission of my participation ial of payment of claims. I agree no benefits will be effecti the date specified at the top of this form.

I hereby authorize any licen hysic medical practitioner, hospital, clinic or othe dical edically related facility, the Veterans Administration, medical In tion Bureau (MIB), or any other organi n, institutio rance or reinsurance company, to disclose release any info ion in its possession about the me history, mental hysical condition or treatments of myse /or my dependents ge Benefit Group or its des e. A photostatic copy authorization shall be considere s effective and valid as the ginal.

| **Signature** | **Date** |
|---|---|
| | |