# ENROLLMENT FORM 2024

## 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<br>☐ Female | |
| **Date of Birth** | **Client Assignment**<br>☐ City of Houston ☐ Harris County ☐ _____ | | |
| **Address** | **City** | **State** | **Zip** |
| | | | |

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

## Medical Coverage Options

**Choose One Option Only**

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

**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<br>☐ Female | | |
| Dependent | | ☐ Male<br>☐ Female | | |
| Dependent | | ☐ Male<br>☐ Female | | |
| Dependent | | ☐ Male<br>☐ Female | | |

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## 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?** ☐ Employee ☐ Spouse ☐ Child(ren) | **Name of Carrier** | **Policy/ID#** | **Effective Date** |
|---|---|---|---|
| | | | |

| **Will prior coverage remain active when coverage under this employer's plan goes into effect?** ☐ Yes ☐ 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** |
|---|---|---|---|
| | | | |

## 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** |
|---|---|
| | |

Fringe Benefit Group - (866) 866-3424