



Allied Benefit Systems, Inc.  
 208 S. LaSalle St. Suite 1300  
 Chicago, IL 60604  
 Tel 312-906-8080  
 Fax 312-906-8359  
 www.alliedbenefit.com

## Emmons School District #33

# ENROLLMENT APPLICATION

<b>SECTION 1: FOR ABS USE ONLY.</b>		<b>EFFECTIVE DATE</b>	<b>EMPLOYMENT DATE</b>	<b>TERMINATION DATE</b>
<b>SECTION 2: PLEASE COMPLETE THE SECTION BELOW.</b>				<b>Group #</b> A04121C
<b>GROUP NAME</b> Emmons SD #33	<b>LOCATION</b>	<b>EMPLOYMENT DATE</b>	<b>DATE INSURANCE WAITING PERIOD BEGAN - IF DIFFERENT:</b>	
<input type="checkbox"/> NEW ENROLLEE <input type="checkbox"/> LATE APPLICANT <input type="checkbox"/> SPECIAL ENROLLMENT (SEE REVERSE) <input type="checkbox"/> CHANGE IN A CURRENT MEMBER'S STATUS				
<b>SOCIAL SECURITY NUMBER</b>		<b>APPLICANT NAME (PLEASE PRINT)</b>		
<b>STREET NUMBER</b>		<b>CITY</b>	<b>STATE</b>	<b>ZIP</b>
<b>GENDER:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>MARITAL STATUS</b> <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W	<b>DATE OF BIRTH</b>	<b>(Area) PHONE NUMBER</b>	
<b>LIFE AMOUNT</b>	<b>BENEFICIARY</b>	<b>RELATIONSHIP</b>		
PLEASE SELECT:            MEDICAL COVERAGE: <input type="checkbox"/> Single <input type="checkbox"/> Single + Child(ren) <input type="checkbox"/> Single + Spouse <input type="checkbox"/> Family  DENTAL COVERAGE: <input type="checkbox"/> Single <input type="checkbox"/> Single + Child(ren) <input type="checkbox"/> Single + Spouse <input type="checkbox"/> Family				
<b>SECTION 3: COMPLETE THE FOLLOWING IF APPLYING FOR DEPENDENT COVERAGE.</b>				
(Dependents must be listed below to be eligible for coverage)				
<b>NAME OF DEPENDENT</b>	<b>RELATIONSHIP</b>	<b>GENDER</b>	<b>DATE OF BIRTH</b>	<b>SOCIAL SECURITY NO.</b>
Spouse:	SPOUSE			
Dep 1:				
Dep 2:				
Dep 3:				
Dep 4:				
DO YOU HAVE A CERTIFICATE OF COVERAGE? <input type="checkbox"/> YES - IF YES, PLEASE ATTACH <input type="checkbox"/> NOT APPLICABLE, I HAVE BEEN COVERED UNDER THIS EMPLOYERS' MEDICAL PLAN FOR 12 OR MORE CONSECUTIVE MONTHS IF BLANK, THE PLAN WILL ASSUME "NO" <input type="checkbox"/> NO				
DO YOU OR ANY OF YOUR DEPENDENTS HAVE OTHER GROUP MEDICAL OR MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE PROVIDE THE FOLLOWING INFORMATION:				
<b>NAME OF INDIVIDUAL WITH OTHER COVERAGE</b>		<b>INSURANCE CARRIER OR TPA</b>		
<b>STREET NUMBER OF CARRIER OR TPA</b>		<b>CITY</b>	<b>STATE</b>	<b>ZIP</b>
<b>WAIVER OF COVERAGE:</b> <input type="checkbox"/> MEDICAL				
<input type="checkbox"/> ARE YOU DECLINING DUE TO COVERAGE UNDER ANOTHER PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO (IF BLANK, THE PLAN WILL ASSUME "NO")    IF YES, IS THIS OTHER COVERAGE COBRA? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> APPLICANT ELECTS TO BE COVERED ONLY BY MEDICARE <input type="checkbox"/> DEPENDENT SPOUSE ELECTS TO BE COVERED BY MEDICARE <input type="checkbox"/> OTHER (PLEASE EXPLAIN) _____				
<b>IMPORTANT NOTICE</b>				
If you refuse coverage for yourself, you automatically refuse that coverage for any dependents. If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. Also, you must indicate the reason for declining enrollment to later be eligible under the special enrollment rules. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.				
The pre-existing conditions limitation is stated in the summary plan description. You and/or your dependants have the right to demonstrate creditable coverage by requesting a certificate of coverage from your prior plan or insurer. If necessary and requested, this plan will assist you in obtaining this certificate.				
I certify the above information is true and correct.				
SIGNATURE OF EMPLOYEE			DATE SIGNED	

**\*IF APPLYING FOR COVERAGE UNDER THE SPECIAL ENROLLMENT RULES, PLEASE COMPLETE THE REVERSE SIDE**