ADVANCED BENEFIT SOLUTIONS, L.L.C.

**Reason for Application**
- ❒ New Hire
- ❒ Open Enrollment
- ❒ Add/Delete Dependents
- ❒ Loss of Prior Coverage

**P.O. Box 71490, Phoenix, AZ 85050**

Effective Date_____ Group Number_____Location_____

Instructions page 1: Complete the form in full in ink. Please print or type.

Section 1

**Type of coverage: ❒ Employee Only ❒ Employee + Spouse ❒ Employee + Child(ren) ❒ Full Family**

**Section 2**

EMPLOYER: DATE OF HIRE TITLE

LAST NAME FIRST INITIAL DATE OF BIRTH

ADDRESS CITY STATE ZIP CODE

PHONE NUMBER SOCIAL SECURITY NUMBER

Gender: ❑ Male ❑ Female MARITAL STATUS: ❑ Single ❑ Married

| NAME OF DEPENDENT | RELATIONSHIP | GENDER | DATE OF BIRTH | SOCIAL SECURITY NUMBER (Required by Medicare) |
|---|---|---|---|---|
| * | ***spouse** | | | |
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**Section 3**
**Other Coverage Information**
Do you and your family members have any additional group health coverage (including Medicare) **O YES O NO**
**If yes, please provide Carrier Name, Policy#, Effective Date and who is covered under the Plan:**

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**Section 4**
**To Refuse or Cancel Coverage**

**I do NOT wish to apply for** ❑ Employee ❑ Family

**Reason for refusing coverage: ❑ Other coverage ❑ Covered by Spouse ❑ Medicare/Medicaid**

**❑ Other**_____ _____

**Instructions page 2 continued: Complete the form in full in ink. Please print/type (except for signature).**

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**Section 5 - Change of Coverage:**

To Add Coverage to An Existing Plan: If change is due to marriage, or birth show date and reason
(Please attach copy of birth certificate, marriage certificate, full-time student status form)

I wish to add: ❑ Employee ❑ Dependent ❑ Spouse ❑ Full Family

I wish to delete: ❑ Employee ❑ Dependent ❑ Spouse ❑ Full Family

Reason for Change: _____

Date of Marriage:_____ Date of Divorce_____

Date of Birth:_____ Date "other" Coverage effective_____ Termed_____

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**Section 6**

Beneficiary's Full Name(s) : _____ Relationship: _____

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**Section 7**

I authorize payroll deductions for my share, if any, of the cost of the coverage(s) applied for.

I agree that:

(1) No coverage will be effective until the effective date assigned by the plan administrators following its approval of this application;

(2) No agent has authority to waive any requirement or a complete answer to any question;

(3) My employer shall represent me when receiving notices (including contribution and termination notices), when transmitting change requests and other information and when paying my contribution for this coverage.

I certify that all statements are complete and true to the best of my knowledge, that any contract which may be issued to me shall be binding only if each statement included in this application is complete and true.

In accordance with HIPAA regulations concerning Protected Health Information (PHI), I authorize any physician, medical facility, insurer, employer having information as to employment, medical coverage, or medical care, treatment or advice for any physical or mental condition of me, my spouse, or my children, or any other non-medical information, to release such information to it's administrators to determine eligibility for coverage.

I agree that the administrator may release such information to its representatives or reinsurers or as permitted by law.

I understand that any charge involved for the cost of these records will be my responsibility.

I represent that all statements and answers made in this application and on any attached papers are complete and true

A copy is valid as the original.

Signature _____ Date _____

**Please supply Certificate of Creditable Coverage when applying.**