HUMAN TECHNOLOGIES
GROUP BENEFIT PLAN ENROLLMENT FORM

LAST NAME: ______________________________

FIRST NAME: ______________________________

MIDDLE INITIAL: _____ SUFFIX _____ SEX: ☐ MALE ☐ FEMALE

SOCIAL SECURITY #: __________-_____-________

DATE OF BIRTH: _____/_____/_____ DATE OF HIRE: _____/_____/_____

FOR EMPLOYER USE ONLY

EFFECTIVE DATE:

EMPLOYER NAME: HUMAN TECHNOLOGIES

DEPARTMENT: ☐ HEALTH & WELFARE

☐ HUMAN TECHNOLOGIES

STATUS: ☐ ACTIVE (FT) ☐ COBRA

ADDRESS:

____
STREET

____
CITY, STATE, ZIP

____
COUNTY

(__________) __________ - __________
PHONE

MARITAL STATUS

☐ SINGLE ☐ MARRIED

☐ DIVORCED ☐ LEGALLY SEPARATED

☐ SIGNIFICANT OTHER

SPOUSES DATE OF BIRTH: _____/_____/_____

PLAN:

HYBRID ☐

HDHP 2600 ☐

HDHP 5500 ☐

TYPE OF COVERAGE:

EMPLOYEE ONLY ☐

EMPLOYEE + ONE ☐

EMPLOYEE + FAMILY ☐

***☐ I decline/waive the coverage available to:

☐ Myself ☐ Spouse ☐ Children, because:

☐ My dependents and/or myself are under another policy/group plan

EMPLOYER NAME: ______________________________

CARRIER NAME: ______________________________

OTHER REASONS: ______________________________

DO YOU HAVE OTHER HEALTH COVERAGE: ☐ Yes ☐ No

______________________________ ______________________________
IF YES, NAME OF POLICY HOLDER POLICY NUMBER

______________________________ ______________________________ (_____) __________ - __________
OTHER CARRIER NAME CITY, STATE, ZIP PHONE

EFFECTIVE DATE OF MEDICAL COVERAGE: _____/_____/_____ EFFECTIVE DATE OF DENTAL COVERAGE: _____/_____/_____

TYPE: ☐ FAMILY ☐ SINGLE COVERAGE: ☐ MEDICAL ☐ DENTAL ☐ VISION ☐ RX

ARE YOU OR YOUR SPOUSE ENROLLED IN AN IRS-QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN WITH A HEALTH SAVINGS ACCOUNT (HSA)? ☐ YES ☐ NO

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SPOUSE INFORMATION (MUST BE COMPLETED IF APPLICABLE)

______________________	____	____/____/____	________-_____-________
LAST NAME, FIRST NAME, MI	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER

SPOUSE'S COVERAGE:

CURRENT PRIMARY PROVIDER:______________________________

PRIMARY PROVIDER ADDRESS:______________________________

MEDICARE ELIGIBLE? ☐ YES ☐ NO

"PART A" EFFECTIVE DATE: ______/______/______

"PART B" EFFECTIVE DATE: ______/______/______

"PART D" EFFECTIVE DATE: ______/______/______

IF UNDER AGE 65, PLEASE PROVIDE REASON ON MEDICARE:

____

IS SPOUSE EMPLOYED? ☐ YES ☐ NO

ENROLLED IN GROUP HEALTH PLAN? ☐ YES ☐ NO

TYPE OF COVERAGE: ☐ SINGLE ☐ FAMILY (IF FAMILY COVERAGE, PLEASE CHECK DEPENDENTS COVERED UNDER SPOUSE PLAN BELOW – SEE **)

☐ MEDICAL ☐ DENTAL ☐ VISION ☐ PRESCRIPTION

EFFECTIVE DATE OF MEDICAL COVERAGE: ______/______/______

EFFECTIVE DATE OF DENTAL COVERAGE: ______/______/______

DOES SPOUSE HAVE OTHER HEALTH COVERAGE:

____
CARRIER NAME

____
POLICY NUMBER

____
STREET ADDRESS

(__________) __________ - __________
PHONE

____
CITY, STATE, ZIP

CHILD(REN) INFORMATION

Last Name, First Name, MI	Sex	Relationship	Date of Birth	Social Security Number	**	School/College City, State	Enrolled Semesters	Disabled Y / N
______________	____	________	____/____/____	_____-_____-_______	☐	______________	________	☐ / ☐
______________	____	________ ☐	____/____/____	_____-_____-_______	☐	______________	________	☐ / ☐
______________	____	________	____/____/____	_____-_____-_______	☐	______________	________	☐ / ☐
______________	____	________	____/____/____	_____-_____-_______	☐	______________	________	☐ / ☐

I authorize payment of benefits to any doctor, physician or other provider for service that he/she may render to me or my family. I certify that all the above information is correct to the best of my knowledge. I desire to participate in the group medical program.

Under federal law it is a crime to knowingly and willfully make a false statement in connection with the delivery or payment for health care benefits or services (18 USC SEC. 1035). It is also a federal crime to attempt to defraud a health program or to knowingly and willfully steal or otherwise convert money from a health care fund (18 USC SEC. 669 and 18 USC SEC. 1347). These crimes are punishable by a fine or imprisonment or both.

______________________________________ ______________
SIGNATURE DATE

For Lifetime Benefit Solutions Use Only: ____

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