Plan Option (Circle one)
1 2 3

Enrollment Form

P.O. Box 11088
Charlotte, NC 28220

healthgram

Effective Date: ☐ New ☐ Change Explain:

Company Name (Employer)	Division/Branch/Plant	Group/Policy Number
Employee's Name (First, M.I., Last)	Date Employed	☐ Hourly ☐ Salaried ☐ Retiree ☐ Other:
Address	Home #: Work #:	Salary $ ☐ Hourly ☐ Bi-Weekly ☐ Monthly ☐ Annually
City, State, Zip	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated	Occupation or Position

Please check each coverage option that is offered by your employer. Enter the amount for Life Insurance if it is optional.

Coverage Election	Medical	Dental	Vision	Life Insurance	AD&D	STD	LTD	Beneficiary Name
Employee								
Spouse								
Children								

ENROLLMENT – ONLY INDIVIDUALS LISTED BELOW WILL BE ENROLLED IN THE ABOVE SELECTED COVERAGE

Employee (First, M.I., Last)			Spouse (First, M.I., Last)	Date of Marriage	
Social Security Number	Date of Birth	Sex ☐ Male ☐ Female	Social Security Number	Date of Birth	Sex ☐ Male ☐ Female
#1 Dependent (First, M.I., Last)	Relationship to Employee		**#2 Dependent (First, M.I., Last)**	Relationship to Employee	
Social Security Number	Date of Birth	Sex ☐ Male ☐ Female	Social Security Number	Date of Birth	Sex ☐ Male ☐ Female
#3 Dependent (First, M.I., Last)	Relationship to Employee		**#4 Dependent (First, M.I., Last)**	Relationship to Employee	
Social Security Number	Date of Birth	Sex ☐ Male ☐ Female	Social Security Number	Date of Birth	Sex ☐ Male ☐ Female

Are you or any of your dependents covered by any other health insurance, supplemental policy, **Medicaid, or Medicare**? ☐ Yes ☐ No
If yes, name of insurer and subscriber:
_____
Name of those covered by other insurance: _____ Policy #: _____

I hereby request coverage under my Employer's Health Plan and authorize my employer to deduct from my earnings any required contributions. I have a regularly scheduled work week with the employer named above at least equal to the minimum required for eligibility under the Plan.

Release of Medical Information
By signing this form, I authorize my physician, medical professional, hospital, clinic, or other medically related facility, insurance company, or other organization, institution or person, that has any records or knowledge of me or my health, or my dependents or their health, to give such information to Healthgram, Inc., if requested.

Notice of Enrollment Rights
If you are declining enrollment for yourself or your dependents, (including your spouse) because of other health benefit plan 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. If you do not enroll for yourself or your dependents within 30 days after your coverage ends, you may enroll as a Late Enrollee. 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.

Are you declining enrollment for yourself or your dependent because you or your dependents have coverage under another health plan? ☐ Yes ☐ No

Employee Signature: _____ Date: _____