GROUP BENEFIT ENROLLMENT FORM

Freedom Care

To Be Completed by Employer:

Facility Name:
Freedom Care

Check One:	***Reason for Application:***
☐ Enrollment Effective date: ____/____/____	☐New Hire ☐Annual open enrollment ☐Cobra
☐ Termination Effective date: ____/____/____	☐Loss of coverage*
☐ Change Effective date: ____/____/____	☐Rehire (date)____/____/____☐Other: __________________
	**Include proof*

To be Completed by Employee:

Medical- Total Plan Concepts

☐ Single

☐ EE + Child(Ren)

☐ Elect ☐ Waive

Employee's Last Name:	Employee's First Name:	MI	Social Security Number - -

Employee's Address:	Apt #:	City	State	Zip Code

Date of Birth / /	Sex: ☐Male ☐Female	Union Employee: ☐Yes ☐No	
Date of Hire: / /	Hours Worked per week:	Occupation:	Home Phone Number:

Dependent information:

Add	*Drop*		Last Name	First Name	Mi	Sex	DOB	FT Student	Social Security #:
							/ /		- -
		Child Name					/ /		- -
		Child Name					/ /		- -
		Child Name					/ /		- -

Did you have prior medical coverage? **Please include certificate of prior carrier* ☐Yes ☐No Name of Carrier:			Type of coverage: ☐Single ☐Dependents
Policy #:	Type of coverage:	Coverage Start Date: / /	Coverage End Date: / /

Are any of the enrollees currently covered under any other insurance? ☐Yes ☐No Name of carrier:			Type of coverage: ☐Single ☐Dependents	
Policy #:	Coverage Start Date:	Medicare Part A eff. Date: / /	Medicare Part B eff. Date: / /	Medicare Part D eff. Date: / /

I request benefits for the coverage(s) indicated above under the group coverage issued sponsored by my employer and authorize deductions from my earnings of any required contributions for any such coverage for which I am or may later become eligible. On behalf of myself I apply or as indicated, decline to apply for those benefit(s) for which I am eligible. I state that the information given as part of my enrollment request is true and correct to the best of my knowledge. I understand and agree that any incorrect statements material to the risk made by me in this enrollment request may invalidate my benefits(s) and result in claim denials and that all statements made by me shall be deemed representations and not warranties. I am aware that any person, who knowingly files a statement of claim, application for insurance containing any false or misleading information, may be subject to criminal and civil penalties. Any benefits applied for shall be effective according the terms of my employer group health benefit plan.

To the best of my knowledge I am an employee working the weekly hours shown above at the employer's regular place of business, and I agree any information shown above including the refusal section is correct and my signing below indicates that I understand all information given is subject to verification.

I authorize any physician, insurer hospital clinic or other organization that has any records or knowledge of me, to give to the insurer, including its reinsurers; such information.

I agree that my Employer acts as my agent in all dealings with the Plan(s), and that all notices given to him are binding upon me. I also agree that my participation in the benefit(s) and the authorization and agreements stipulated herein are subject to any future amendments to the Plan(s).

Employee Signature:	**Date:**