



EMPLOYEE ELECTION FORM

Please print clearly in CAPITAL letters

Please fill in the circles completely

- New Subscriber
 Member adding line of coverage
 WAIVER (Signature Required)
 COBRA
 Retiree

Company Name: _____ KAIG Company ID#: _____ Business Phone#: () _____

1 Last Name _____ First Name _____ MI _____ Title (Jr., III, etc.) _____
 Street Address Number _____ Street Address Name _____ Apt# _____
 City _____ State _____ Zip Code _____ Employee E-mail Address _____
 Social Security# _____ Date of Birth (MM-DD-YY) _____ Gender M F Marital Status S M On your effective date, will you be actively at work on a full-time basis for this employer? Y N Hrs worked/wk _____
 Home Phone# _____ Full-time Hire Date (MM-DD-YY) _____ Requested Effective Date (MM-DD-YY) _____ KAIG USE ONLY: **A**

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Last, Full First, M.I.	Social Security #	Birth Date	Sex (M/F)	F/T Student (Y/N)*	Disabled (Y/N)	POS or HMO only:		Existing Patient (Y/N)
						Line 1: PCP Info: Physician Name	Line 2: OB/GYN Info: Physician #	
Emp								
Sp								
Chd								
Chd								
Chd								

*If full time student, please submit proper form, or appropriate verification of student status (e.g. class schedule, statement from Registrar's office, cancelled check)
 Participating Dentist / Provider Code / Dental Office #: _____ Existing Patient: Y N
 Are you or any of your dependents eligible for Medicare? If Yes: Effective Date (Part A) ____/____/____ Effective Date (Part B) ____/____/____

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HEALTH PLAN	DENTAL PLAN	VISION PLAN	Plan Name	Benefit Amount	Smoker?
Gp#: _____ Carrier: _____ Plan: _____ <input type="radio"/> Employee Only <input type="radio"/> Employee & 1 Child <input type="radio"/> Employee & Spouse <input type="radio"/> Family <input type="radio"/> Over 65 & Working FT <input type="radio"/> Over 65 & Retired <input type="radio"/> Waive Coverage	Gp#: _____ Carrier: _____ Plan: _____ <input type="radio"/> Employee Only <input type="radio"/> Employee & 1 Child <input type="radio"/> Employee & Spouse <input type="radio"/> Family <input type="radio"/> Waive Coverage	Gp#: _____ Carrier: _____ Plan: _____ <input type="radio"/> Employee Only <input type="radio"/> Employee & 1 Child <input type="radio"/> Employee & Spouse <input type="radio"/> Family <input type="radio"/> Waive Coverage	<input type="radio"/> Life AD&D _____ \$ _____ <input type="radio"/> Vol. Life _____ \$ _____ <input type="radio"/> Vol. AD&D _____ \$ _____ <input type="radio"/> Vol. Sp. Life _____ \$ _____ <input type="radio"/> Vol. Dep. Life _____ \$ _____ <input type="radio"/> STD _____ \$ /wk _____ <input type="radio"/> Vol. STD _____ \$ /wk _____ <input type="radio"/> LTD _____ \$ /mo _____ <input type="radio"/> Vol. LTD _____ \$ _____ <input type="radio"/> Suppl. Life/AD&D _____ \$ _____		<input type="radio"/> Y <input type="radio"/> Y <input type="radio"/> Y <input type="radio"/> Y <input type="radio"/> Y <input type="radio"/> Y <input type="radio"/> Y

4 Employee Occupation _____ Class _____ Annual Salary _____
 Primary Beneficiary _____ Relationship _____
 Secondary Beneficiary _____ Relationship _____

5 OTHER INSURANCE INFORMATION
 Will you or your dependents continue health coverage with another insurer? Yes No
 Other Health Insurer Name _____
 Who is covered? Self Spouse All Policy # _____
 Effective Date ____/____/____ Term Date ____/____/____

CERTIFICATION: I hereby apply, on behalf of myself and each dependent listed above, for the coverage(s) indicated. If accepted, coverage will be provided according to the terms and conditions of the benefit plan(s) between the appropriate carrier(s) and my employer. I agree to be bound by the benefit plan(s) of which this form will become part. I also agree to pay current and future charges for coverage(s) provided in excess of any employer contribution. The recorded answers on this form are to the best of my knowledge and belief full, complete and true as of this date. I further certify that I am the spouse, parent or legal guardian of the dependents listed above. If you have any questions concerning the benefits and services provided by or excluded under this agreement, please contact a Service Representative before signing this Election Form.

THIS IS NOT AN APPLICATION FOR INSURANCE

6 EMPLOYEE SIGNATURE _____ DATE ____/____/____
 EMPLOYER SIGNATURE / VERIFICATION _____ DATE ____/____/____

KELLY & ASSOCIATES INSURANCE GROUP, INC.

WAIVER OF INSURANCE COVERAGE

Medical - Notice of Special Enrollment Period

If you are declining enrollment for yourself and/or your spouse and dependent(s) because of other health insurance coverage, you may in the future be able to enroll yourself and/or your spouse and dependent(s) in this plan, provided that you request enrollment within 30 days after your other coverage ends. If you decline enrollment for yourself and/or your spouse and dependent(s) because of other health insurance coverage, you must provide details concerning your situation on the front of this form in order to preserve your special enrollment rights in the future. If you are declining coverage for yourself and/or your spouse and dependent(s) for any other reason, you cannot join the Plan later unless you have a new dependent as a result of marriage, birth, adoption, placement for adoption, or during open enrollment period, if applicable. You may then be able to enroll yourself and your spouse/dependent(s), provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you decline coverage for yourself and/or your spouse and dependent(s) because of other health coverage and you fail to fill out the front of this form concerning your (and/or your spouse/dependent's) other coverage or if you fail to request plan enrollment within 30 days after your (and/or your spouse/dependent's) other coverage ends, you will not be eligible to enroll yourself, spouse or your dependent(s) during the special enrollment period discussed above and you will need to wait until the next open enrollment period to enroll in the plan's health coverage.

Non - Medical

If you are voluntarily declining the non-medical coverages provided by your employer, you may choose to enroll at a later date depending upon the coverage now being waived. With the late enrollment your cost may be higher, a health questionnaire may be required and the effective date of your coverage may be delayed or denied. If coverage is non-contributory (employer pays entire cost) waivers are not permitted.