HEALTH BENEFIT PLAN ENROLLMENT FORM

COMPLETE ALL SECTIONS BELOW FOR NEW ENROLLMENTS. INCOMPLETE FORMS WILL BE RETURNED. PLEASE REVIEW THE STATEMENT OF HIPAA PORTABILITY RIGHTS ON THE BACK.

Company / Employer Name: Gage Marine Corporation

Type of Benefits:

❒ Copay Plan ❒ HSA Plan

EMPLOYEE NAME (FIRST) (INITIAL) (LAST)

ADDRESS

SOCIAL SECURITY NO. (required by law) _____-_____-_____

SEX (M OR F) _____

BIRTH DATE _____-_____-_____

CITY STATE ZIP

DATE OF HIRE ____-____-____

☐ Single ☐ Widowed ☐ Divorced ☐ Married

HOME PHONE NUMBER ( )

WORK PHONE NUMBER ( )

OCCUPATION/JOB TITLE _____

EARNINGS (IF APPLICABLE) $_____PER_____

E-MAIL ADDRESS

FOR COMPANY USE ONLY

PLAN# **DEPT.** **EFFECTIVE DATE**

1006118

DEPENDENTS **(Use additional paper, if necessary)**

FIRST INITIAL LAST	SOCIAL SECURITY NUMBER (required by law)	BIRTH DATE	SEX	RELATIONSHIP	RESIDES WITH EMPLOYEE YES / NO		TO BE COVERED YES / NO	
LEGAL SPOUSE Marriage Date ___-___-___								
List Child								
List Child								
List Child								
List Child								

Any dependents listed above must meet the definition of a dependent as listed in the Summary Plan Description.

I UNDERSTAND that providing inaccurate or incorrect information to any of the questions on the Enrollment Form may be considered health care fraud.

I HEREBY AUTHORIZE my employer to make any required payroll deductions for this coverage. I certify that the information provided is true and correct.

SIGNATURE OF APPLICANT **DATE**

COMPLETE WAIVER FORM ON BACK IF YOU AND/OR YOUR DEPENDENTS CHOOSE NOT TO BE COVERED BY THIS HEALTH BENEFIT PLAN

HEALTH COVERAGE WAIVER FORM

(Complete Waiver only if you are waiving coverage for yourself & / or any dependent)

COMPANY / EMPLOYER NAME:	**GROUP NUMBER**
EMPLOYEE NAME: (LAST) (FIRST) (INITIAL)	**SOCIAL SECURITY NUMBER**

I decline to enroll in the health coverage for:

☐ Myself ☐ My Spouse Reason for waiver: ☐ The existence of other coverage _____ (Plan Name)

☐ My Dependent Child/Children (please list) ☐ Other reason (explain)_____

1._____ 4._____

2._____ 5._____

3._____ 6._____

I understand that this waiver of coverage may affect the ability of each person listed above to obtain coverage at a later date

EMPLOYEE'S SIGNATURE _____ DATE SIGNED _____

SPOUSE'S SIGNATURE _____ DATE SIGNED _____
(If Spouse is waiving coverage)

Statement of HIPAA Portability Rights

Right to get special enrollment in another plan. Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment according to the Special Enrollment provisions of your plan (usually within 30 or 60 days). (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

- Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

You or your eligible dependents may also have special enrollment rights in this Plan as a result of:

- The loss of eligibility for coverage under Medicaid or a state sponsored Children's Health Insurance Program (CHIP) if request for enrollment is made within 60 days after loss of such coverage: or;
- Becoming eligible for a premium subsidy from either Medicaid or CHIP for coverage under this Plan, if request for enrollment is made within 60 days after the date of the Determination Letter advising of the eligibility for the premium subsidy, issued by either Medicaid or SHIP. You should consult with your local Medicaid or CHIP office regarding rights to the premium subsidy.

Prohibition against discrimination based on a health factor. Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

OTHER HEALTH INSURANCE INFORMATION

Other Health Coverage?* ❑ **Yes (complete below)** ❑ **No**

***Please complete the fields below if you are going to continue to have coverage through another carrier in addition to this coverage.**

Please check the coverage currently being provided elsewhere: ___ Medical ___ Pharmacy ___ Dental ___Vision

List all family members, including yourself, who will continue to be covered by other health coverage in addition to this plan:

Self: □ Yes □ No	**Spouse:** □ Yes □ No (If yes, continue below)		**Child(ren):** □ Yes □ No (If yes, continue below)	
SPOUSE:	Date coverage will end:	CHILD:		Date coverage will end:
CHILD:	Date coverage will end:	CHILD:		Date coverage will end:
CHILD:	Date coverage will end:	CHILD:		Date coverage will end:

Name, Phone Number and Address of other insurance company:	Policy/Certificate Number:	Effective Date:
Policyholder's Name:	Social Security Number:	Date of Birth:

If you and/or your dependents are enrolled in Medicare Part A, Part B, and/or Part D, or Medicaid, please complete the following fields:

Enrollee's name(s):	Medicare or Medicaid ID#:	Medicare Part A Effective Date:	Medicare Part B Effective Date:	Medicare Part D Effective Date:	Medicaid Effective Date:

IF PARENTS OF DEPENDENT CHILD(REN) WERE NEVER MARRIED OR IF THEY ARE NOW SEPARATED OR DIVORCED: Please answer the following questions for dependent children in order to determine which coverage has primary liability.

Date of divorce or separation (if applicable):	Is there a court order making one parent responsible for the child's medical, dental, or vision expenses? □ Yes □ No ***If yes, please provide a copy of the divorce decree or parenting plan.**

Which parent has physical custody of the child? Name _____ DOB _____

Has the parent with custody remarried? □ Yes □ No

If yes, does the step-parent cover this child? □ Yes □ No *If yes, please provide insurance information below

Name, Phone Number and Address of other insurance company:	Policyholder's Name: Policyholder's Date of Birth:	Policy/Certificate Number:

Effective Date of Coverage: Termination Date of Coverage (if applicable):	Type of Coverage: ❒ Medical ❒ Prescription ❒ Dental ❒ Vision	Members on the Plan: _____ _____ _____ _____