



EMPLOYEE ENROLLMENT FORM

OFFICE USE ONLY

EFF. DATE: _____

LIFE AMOUNT: _____

CLASS: _____

PLAN ID#: **402**

PO Box 24708
 Omaha, NE 68124-0708
 402-955-1644, 800-223-5508, fax: 402-955-1646

- Initial Enrollment
 Open Enrollment
 Special Enrollment

Employer: **Dlorah, Inc.** Division/Location: _____ Date Employed: _____

Employee's Name _____ / / SSN: _____
Last First M.I. M F Date of Birth

Street Address _____ City _____ State _____ Zip _____

Marital Status Single Married Hrs Worked Per Week _____ Annual Earnings _____ Job Title _____

Dependents to be enrolled:

Spouse's Last Name	First Name	M.I.	Home Phone #	Date of Birth	M	F	Social Security Number
_____	_____	_____	_____	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dependent's Last Name	First Name	M.I.	Relationship	Date of Birth	M	F	Social Security Number
_____	_____	_____	_____	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dependent's Last Name	First Name	M.I.	Relationship	Date of Birth	M	F	Social Security Number
_____	_____	_____	_____	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dependent's Last Name	First Name	M.I.	Relationship	Date of Birth	M	F	Social Security Number
_____	_____	_____	_____	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Are any dependent's address different from the employee's address? Yes No. If yes, indicate dependent's address on the back of this form.

Did you or any of your dependents have group or individual medical coverage within 12 months prior to the effective date of this plan. Yes No
 If "Yes", please attach your Certification of Prior Creditable Health Coverage. If you do not have it yet, you can fax or mail to the above address as soon as you receive it.

Do you or any of your dependents have other group medical coverage in addition to this plan? Yes No
 If "Yes," _____
Family Members Covered Employer Carrier
 Please answer no if other coverage will be discontinued when this coverage will be effective.

Coverage Requested: If available under your plan, you may select one of the following options for yourself and your dependents if covered.

- | | | | | |
|--|--|---|--|--|
| <u>Medical plan 1</u> | <u>Medical plan 2</u> | <u>Life Coverage</u> | <u>Dental plan 1</u> | <u>Dental plan 2</u> |
| <input type="checkbox"/> Employee Only | <input type="checkbox"/> Employee Only | <input type="checkbox"/> Employee Life (basic) | <input type="checkbox"/> Employee Only | <input type="checkbox"/> Employee only |
| <input type="checkbox"/> Family | <input type="checkbox"/> Family | <input type="checkbox"/> Dependent Life (basic) | <input type="checkbox"/> Family | <input type="checkbox"/> Family |
| | | <input type="checkbox"/> Supplemental Life (Additional Life Enrollment and Evidence of Insurability forms required) | | |

Beneficiary's full name and relationship _____

Authorizations:

I hereby apply for group coverage for which I am or may become eligible, and if the plan of coverage is on a contributory basis, I authorize my employer to deduct my share of the cost from my salary. I understand that no coverage shall be effective until approved by the plan administrator. I represent that my answers and statements are true and complete to the best of my knowledge and belief. I understand that my employer and the plan administrator shall rely and act upon such answers and statements and any misstatements or omissions of information material to the risk that are made on this application may be the basis for rescission or cancellation of my coverage under the group plan (s). I understand and hereby authorize that any benefits payable for services rendered by any network or Preferred Provider to myself or any of my covered dependent(s) will be paid directly to such providers.

To all physicians, medical or dental practitioners, hospitals, clinics, other medical care facilities or other providers of medical or dental care services insurers and employers: I authorize you to release all medical information about me, my spouse or my children to the plan administrator and/or Cypress Benefit Administrators or any of its affiliates and any insurers or re-insurers. I authorize Cypress Benefit Administrators to release any such information to any medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person as may be necessary to administer the plan or policy. A photographic copy of this authorization shall be as valid as the original.

HIPAA & WHCRA Notices:

I hereby acknowledge that I received the notices required to be given under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Women's Health and Cancer Rights Act of 1998 (WHCRA) which were attached hereto.

Employee's Signature _____ Date _____

Must Be Signed and Dated.

Waiver of Group Coverage:

I hereby certify that I have been given the opportunity to apply for coverage under my employer’s group plan and after careful consideration, I have decided to waive coverage for:

I hereby waive Group Medical Coverage for: Employee Spouse Dependent Children

I have decided not to apply for coverage because:

- ___ Coverage exists under my spouse of Military Health Plan.
- ___ Coverage exists under another group health plan or other health insurance policy.

Please provide the name and address of the other health insurance coverage, employer (if applicable) and policy number

____ Other (please explain)_____

I hereby waive Group Dental Coverage for: Employee Spouse Dependent Children

I have decided not to apply for coverage because:

- ___ Coverage exists under my spouse of Military Health Plan.
- ___ Coverage exists under another group health plan or other health insurance policy.

Please provide the name and address of the other health insurance coverage, employer (if applicable) and policy number

____ Other (please explain)_____

I hereby waive the following Coverage(s):

- Life Coverage Dependent Life Coverage Supplemental Life Coverage

I have decided not to apply for coverage for myself or my dependents because of other health insurance coverage or as I have indicated above. I may in the future be able to enroll myself or my dependent in this plan, provided that I request enrollment within 31 days after my other coverage ends. In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents, provide that I request enrollment within 31 days after marriage, birth, adoption or placement for adoption.

I fully understand that if I fail to indicate that medical coverage is being waived because I have other coverage under another group health plan or other health insurance coverage, I may not be eligible to enroll in the future under the special enrollment provision and may be eligible for coverage as a late enrollee subject to an 18-month preexisting condition exclusion. Please refer to your summary plan description as to if coverage is available to late enrollees.

HIPAA & WHCRA Disclosures:

I hereby acknowledge that I received the notices required to be given under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Women’s Health and Cancer Rights Acts of 1998 (WHCRA) which were attached hereto.

Employee’s Signature _____ Date _____
(Sign here if you do not want coverage.)

(Detach along dotted line)

HIPAA & WHCRA Notices

Preexisting Condition Exclusion: If you have a condition (whether physical or mental) for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months prior to your enrollment date, you will be subject to a preexisting condition exclusion. Your enrollment date is defined as the first day of coverage, or if there is a waiting period, the first day of the waiting period. A preexisting condition exclusion is the amount of time when care related to that condition will not be covered. The exclusion period will be measured from your enrollment date and will be a period of: (a) 12 months for timely entrants (individuals who enroll when first eligible or under the Special Enrollment Periods provision); or (b) 18 months for late entrants. Please refer to your plan document as to coverage for late entrants. The preexisting condition exclusion will not apply to: (a) newborns or children under the age of 18 who are adopted or placed for adoption if coverage is requested within 31 days of birth, adoption, or placement for adoption provided there is not a break in coverage of more than 63 days; or (b) pregnancy.

Creditable Coverage Certificates: The preexisting exclusion period may be reduced by the number of days you were covered under a prior health plan provided there was not a break in coverage of more than 63 days. You have the right to demonstrate coverage under a prior plan. To do this, you may request a certificate of coverage from a prior health plan or insurer. Your employer will assist you in obtaining a certificate, if necessary. Following our receipt of a certificate of coverage, you will receive a notice stating the length of your preexisting condition exclusion period, if any.

Special Enrollment Rules: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. 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 31 days after marriage, birth, adoption or placement for adoption.

Women’s Health and Cancer Rights Act of 1998: The group health plan you are enrolling under provides medical and surgical benefits in connection with medically necessary mastectomies and also provides benefits for certain reconstructive surgery. This covers reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of all stages of mastectomy, including lymphedemas. Coverage is subject to the plan’s deductible and out-of-pocket requirements consistent with those established for other benefits.