2017-2018 Medical Declaration Form
(Acknowledgement to be completed annually for compliance purposes.)

SECTION 1 – ENROLLMENT EVENTS
Please check all that apply – If you are declining coverage, complete Sections 1, 2, 3, 5, 9 & 10.

Enrollment Action:	☐ New Enrollee ☐ Add Dependent	☐ Cancel Enrollee ☐ Cancel Dependent
Effective Date: / /	Are you applying as a result of a special enrollment event? ☐ Yes ☐ No Event: ☐ Marriage ☐ Birth, Adoption, Placement for Adoption ☐ Court Order ☐ Loss of Other Coverage ☐ Other: ________________________ Indicate Event Date: _____ / _____ / __________	List names of those canceling in Section 4 below Event: ☐ Divorce ☐ Death ☐ Terminated Employment ☐ Dependent Child Exceeds Age Limit ☐ Gain of Other Insurance ☐ Other, __________________________ Indicate Event Date: ______ / ______ / __________ Cancel Coverage: ☐ Medical

SECTION 2 – EMPLOYEE INFORMATION
Complete Even if Declining Coverage.

Last Name	First Name	MI (opt)	Suffix	Date of Birth / /	Social Security Number - -
Mailing Address – Street – Apt #		City		State	Zip
Email Address	Gender ☐ Male ☐ Female	Business Phone #	Cell Phone #		Home Phone #
Name of Employer: IMPRIMIS GROUP, FREEMAN+LEONARD AND BRAVO TECH		Date of Employment: / /	Do you normally work at least **30** hours per week? ☐ Yes ☐ No		

SECTION 3 – SELECT COVERAGE

BCBS Medical Plan: ☐ BCBS – BlueChoice BlueEdge H.S.A. MMH3 ($5000 Deductible)

Coverage Level: ☐ Employee Only
☐ Employee/Spouse
☐ Employee Child(ren)
☐ Employee/Family

SECTION 4 – DEPENDENT COVERAGE INFORMATION

Name	Date of Birth	Gender	SSN	
Spouse's Name	Spouse's Date of Birth / /	☐ Male ☐ Female	Spouses SSN: - -	
Child's Name	Child's Date of Birth / /	☐ Male ☐ Female	Child's SSN - -	
Child's Name	Child's Date of Birth / /	☐ Male ☐ Female	Child's SSN - -	
Child's Name	Child's Date of Birth / /	☐ Male ☐ Female	Child's SSN - -	

SECTION 9 – DECLINATION OF HEALTH COVERAGE – complete this section if you have declined a coverage in section 2, for yourself or any eligible dependent.

This is to certify the available coverage has been explained to me. I have been given the opportunity to apply for the coverage offered to me and my eligible dependents and have voluntarily elected to decline the coverage as indicated below. If I desire to apply for coverage at a later date, I understand there may be a delay in the effective date of the coverage as well as a pre-existing condition waiting period.

Employee ______________________________________
Reason for declining: ☐ Other Group Coverage ☐ Medicare ☐ Medicaid ☐ Other, explain: ____
Spouse ______________________________________
Reason for declining: ☐ Other Group Coverage ☐ Medicare ☐ Medicaid ☐ Other, explain: ____
Child(ren) ____________________________________
Reason for declining: ☐ Other Group Coverage ☐ Medicare ☐ Medicaid ☐ Other, explain: ____

SECTION 10 – COVERAGE CONDITIONS

- I am an employee of IMPRIMIS GROUP, FREEMAN+LEONARD or BRAVO TECH working a minimum of 30 hours per week and meet the eligibility requirements for myself and dependents listed on this form, and am eligible to participate in the coverage(s) afforded by my Employer's plan. On behalf of myself and my dependents listed on this Enrollment Application, I am applying for those coverage(s) for which I am eligible. I state that the information given on this Enrollment Application is true and correct. I understand and agree that any intentional misinterpretation of a material fact made by me may invalidate my coverage(s).
- Only those coverage(s) and amounts for which I am eligible will be available to me. I understand that if this Enrollment Application is accepted, the coverage(s) will become effective in accordance with the provisions of the Contract(s)/Plan(s).
- I agree that my Employer acts as my agent. I authorize necessary payroll deductions by Employer, if any, to cover the cost of my coverage(s).
- I understand that my participation in the coverage(s) is subject to any future amendment. I also understand that all notices given to my Employer are applicable to me.
- **I understand that benefit elections will be effective for the entire plan year, and may not be changed until the next open enrollment unless an approved status change is experienced. I also understand that any changes I wish to make resulting from a qualified status change event must be requested in writing and submitted to my HR representative within 30 days from the date of the event.**

Applicant's Signature ____ **Date:** ______________________