GROUP EMPLOYEE BENEFIT TRUST

Submit to:

Benefit Services
PO Box 950
Forest Hill, MD 21050

p 866.902.6227
f 866.903.6227

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Legal Name: IGA Group Employee Benefit Trust
Version: IGA / Enrollment / 0909

ENROLLMENT/MEDICAL INFORMATION

Please complete this fillable form and click the Submit button. Then save it, print it, sign it and fax it to the number shown above.

Begin by selecting ONE of the following boxes: **New Enrollee** **COBRA Enrollee**

COBRA Qualifing Event Date: ____________ *(mm/dd/yyyy)*

COBRA Qualifing Event: ____________

SECTION I. EMPLOYER INFORMATION

Employer Name: ____________ Location (if more than one): ____________

SECTION II. EMPLOYEE INFORMATION

Employee Social Security No. ____________

Last Name:		First Name:		MI:
Address:		City:	State:	Zip Code:
Home Phone:	Single Married	Male Female	Height:	Weight:
Date Of Birth: *(mm/dd/yyyy)*		E-mail:		
Date Employed Full Time: *(mm/dd/yyyy)*		Hours Worked Per Week:	Occupation:	

NOTE: Requested Effective Date of Coverage subject to employer waiting period and other limitations that may apply.

SECTION III. COVERAGE SELECTION *(Subject to the plan options selected by your employer)*

Select ONE of the following: Employee Only EE + Spouse EE + Child(ren) EE + Family

SECTION IV. FAMILY INFORMATION *(please complete for all persons to be covered)*

First Name & M.I. (last name if different)	Gender		DOB	F/T Student*		Height	Weight	Social Security No.
	M	F	MM/DD/YYYY	Yes	No			No Hyphens
Spouse:								
Child:								
Child:								
Child:								
Child:								
Child:								
Child:								
Child:								
Child:								
Child:								

* Full time students ages 19 - 24 must carry 12 credits per semester. Student certification required from accredited college.

SECTION IV. FAMILY INFORMATION (Continued) *(Please complete for all persons to be covered)*

1. Yes No Do you have any family members who are covered under the plan and live at a different address?
   If yes, please provide legal documentation, name and address: ______
2. List family members covered by Medicaid and their effective date: ______
3. List family members covered by Medicare and their effective date: ______
4. If you have Medicare, are you covered by: **Part A:** Yes No **Part B:** Yes No
5. List family members who are disabled and covered under the plan: ______
6. Yes No Do any family members intend to keep other health coverage in addition to this plan?
   If yes, list family members: ______
   and provide the name of the insurance company and policy number: ______

SECTION V. PRIOR MEDICAL/DENTAL COVERAGE INFORMATION

Important: You may be eligible for a pre-existing condition limitation credit. Failure to provide the following information may result in a reduction or delay in payment of benefits.

1. Yes No Have you and/or any dependents applying for coverage been covered by this employer's group medical plan?
   If yes, more than 12 consecutive months less than 12 consecutive months? Coverage Effective Date: ______

2. Yes No If not, have you and/or any dependents applying for coverage been covered under a medical plan other than this employer's plan?
   If yes, please attach **Certificate(s) of Creditable Coverage**. Indicate type of plan:
   Spouse's Employer Group Plan Prior Employer Group Plan Individual Policy Other: ______
   Insurance Company Name: ______ Effective Date: ______ *(mm/dd/yyyy)*
   Reason for termination: ______ Termination Date: ______ *(mm/dd/yyyy)*

SECTION VI. MEDICAL INFORMATION

Questions 1 and 2 to be answered by employee, spouse and all dependents desiring coverage.

1. Yes No Have you or any of your dependents (spouse and/or any child), within the past 5 years, ever been diagnosed as having or been advised to seek treatment for: *(Please select ALL that apply)*

Circulatory, blood or vascular disorder
Heart, liver or kidney condition
Hypertension, high cholesterol or high blood pressure
Stroke, seizures or neurological disorder
Cancer, tumor, polyp or cyst
Diabetes Type I Type II
Mental disorder, alcoholism or drug addiction
AIDS / HIV / Hepatitis or condition of immune system
Birth defects or congenital deformities
Lung disorder, asthma or emphysema
Digestive, gallbladder, thyroid disorders
Organ or bone marrow transplant (received or recommended)
Arthritis, back, neck, joint disorder or replacment
Muscular or systemic condition, Multiple Sclerosis or Lupus

Provide details to any Medical "YES" answers listed above in Question 1

Person's Name	Condition	Date First Treated	Date Last Treated	Diagnosis & Prognosis	Surgery / Hospitalization / Testing / Procedures

2. Have you, or any of your dependents *(spouse and/or any child):*

Yes No Within the past 12 months, have you or any dependent(s) to be insured received, been advised or recommended for any of the following: *(Please select ALL that apply and provide details in the box below)*

Testing
Hospitalization
Surgery
Medical/surgical consultation, advice or treatment for any condition(s)
Abnormal test results or laboratory findings

Are you, or any of your dependents *(spouse and/or any child):*

Yes No Pregnant? If yes, due date: __________________ *(mm/dd/yyyy)*

Yes No Currently being treated for any condition not listed above (ie. infertility)?

Yes No Incurred medical expenses in excess of $10,000 in the last 12 months?

Provide details to any Medical "YES" answers listed above in Question 2

Person's Name	Condition	Date First Treated	Date Last Treated	Diagnosis & Prognosis	Surgery / Hospitalization / Testing / Procedures

3. Are you, or any of your dependents *(spouse and/or any child):*

Yes No Currently taking prescription medications?

Yes No Currently taking an injectable drug?

Provide details to any Medication "YES" answers listed above in Question 3

Person's Name	Medication	Condition	Frequency and Dosage	Length of Time on Medication

SECTION VII. EMPLOYEE AGREEMENT/AUTHORIZATION TO RELEASE MEDICAL INFORMATION - Signature Required

I UNDERSTAND that the above answers shall be the basis for the Plan to issue a Summary Plan Description. **I DECLARE** all statements contained in this entire form are true and correct and that no material information has been withheld or omitted. I understand and agree that the Plan Administrator is not bound by any statement made by or to any agent unless written herein. **I UNDERSTAND AND AGREE** that no coverage will be effective until the date specified by the Plan Administrator.

I HEREBY apply for participation in the Plan for my dependents and myself listed above. To assist the Plan Administrator with determining my creditable coverage, I authorize any insurance company, third party administrator or other authorized carrier, to release to the Plan Administrator certificates of creditable coverage and all such information. **I HEREBY AUTHORIZE** any physician, medical practitioner, hospital, clinic, Veterans administrations facility, other medical or medically related facility, insurance or reinsurance company, or Consumer Reporting Agency, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition, including drug or alcohol abuse, and/or treatment of me or my minor children and other non-medical information of me and my minor children, to release to the Plan Administrator, any and all such information.

I UNDERSTAND that I may request a copy of this authorization at any time. I agree that a photographic copy of this authorization shall be as valid as the original, and that this authorization shall be valid for 2 1/2 years from the date shown below. I understand the information obtained by use of this authorization may be used by the Plan Administrator for health benefit underwriting. Any information obtained will not be released to any person or organization, except to reinsuring companies or other persons or organizations performing business or legal services in connection with my enrollment for the coverage, for any claim, for medical management purposes, or as may be otherwise lawfully required or as I may further authorize.

Any person who, with intent to defraud or knowing that he/she is facilitating a fraudulent act against an insurer, submits an Enrollment, Participation, or other required form or files a claim containing a false or deceptive statement, material misrepresentation or material omission commits a fraudulent insurance act, which is a crime, and subjects the person to civil and criminal penalties.

BY SIGNING BELOW, I UNDERSTAND AND AGREE that all of the above questions must be answered completely and truthfully and that any additional information must be provided and that failure to answer these questions completely and truthfully may result in loss of coverage for any or all those persons included on this application.

Applicant Signature: ______________________________ Date: ______________ *(mm/dd/yyyy)*

Spouse Signature: ______________________________ Date: ______________ *(mm/dd/yyyy)*