INTEGRITY HEALTH®
Join us in good health.℠

EMPLOYER SECTION
Group No: _____ **Effective Date:** _____
Location:_____ **Date of Hire:** _____
HR Rep./Date: _____

Benefits Enrollment Form

This enrollment form should be used to indicate your benefit elections or changes.
Please print and mark all selection boxes clearly.

MUST Select One:	☐ **New Enrollment**	☐ **Open Enrollment**	☐ **Add / Drop Dependent**	☐ **Drop / Change Coverage** ___/___/___	☐ **Beneficiary / Name Change** ___/___/___

Section 1: Employee Information

Full Name (First MI Last): _____ Sex: ☐ M ☐ F
Address: _____ Social Security No.: _____-_____-_____
_____ Date of Birth: _____/_____/_____
City: _____ State: _____ Zip: _____ Home Phone: (_____) _____
Mobile Phone:(_____)_____
Marital/Civil Union Status: ☐ Single ☐ Married ☐ Civil Union Date of Marriage/Civil Union: _____/_____/_____

☐ Legally Separated ☐ Divorced

E-Mail Address:_____

Section 2: Medical Plan

Plan Option	Tier Option
☐ Integrity 10	☐ Employee Only
☐ Integrity 15	☐ Employee & Children
☐ Integrity 15/25	☐ Employee & Spouse/ Two Adults
☐ Integrity 20/30	☐ Employee & Family
	☐ No Coverage (select this box to waive/cancel)

Section 3: Dependent Information

	Full Name (First MI Last)	Date of Birth	Sex	Social Security No.	Dependent Age 26 to 31?		Permanently Disabled Child?	
Spouse		/ /	M F	- -				
Child		/ /	M F	- -	☐ Y	☐ N	☐ Y	☐ N
Child		/ /	M F	- -	☐ Y	☐ N	☐ Y	☐ N
Child		/ /	M F	- -	☐ Y	☐ N	☐ Y	☐ N
Child		/ /	M F	- -	☐ Y	☐ N	☐ Y	☐ N

Section 4: Other Insurance Information

Do you or any dependents listed have coverage under another benefit plan? ☐ No ☐ Yes. Please complete the following:
Name of Policyholder: _____ Name of Sponsoring Employer: _____
Name of Insurance Plan: _____ Type of Plan: ☐ Group ☐ Individual
Type of Coverage: ☐ Medical ☐ Dental ☐ Vision ☐ Medicare
List covered Dependents from Section 3 above: _____

Section 5: Employee Authorization and Acceptance

I hereby certify that I have read the **reverse side** of this enrollment form and agree to the terms of each Benefits Program that I am offered.
Print Name: _____
Employee Signature: _____ Date: _____

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Benefits Authorization

I hereby apply for the coverages for which I am entitled under the terms of the employer's Benefits Programs and I agree to pay any required costs.

I authorize any physician, medical practitioner, hospital, clinic or other medical related facility, benefit manager, reinsurance company or third-party administrator having information as to diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment of me or my dependents and any other non-medical information of me or my dependents to give to Integrity Health or its legal representative any and all such information. Any medical information obtained will not be released to any person or organization except for those associated with the benefits programs, unless lawfully required to receive it.

I acknowledge that I may request a copy of this Authorization. I furthermore acknowledge that a photographic copy of this authorization shall be as valid as the original.

FRAUD STATEMENT: Any person who knowingly and with intent to defraud any insurance company or other person filing an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, is committing a fraudulent act which is a crime and subjects such person to criminal and civil penalties.

IMPORTANT - PLEASE SIGN THE FRONT SIDE OF THIS ENROLLMENT FORM AS YOUR ACKNOWLEDGEMENT AND ACCEPTANCE OF THE ABOVE INFORMATION.

FOR USE BY INTEGRITY HEALTH	
Account:	
Location:	
Eff Date Employee: _____	**Processed Date:** _____
Eff Date Dependent: _____	**User ID:** _____
Remarks:	