

Association Master Trust

HEALTH BENEFITS ENROLLMENT FORM

Association Member (full legal name of company): _____ Division # _____

Association Member Address: _____
Street
City
State
Zip Code

SECTION I: EMPLOYEE INFORMATION

Name _____ Telephone _____
Last
First
Middle Initial

Home Address: _____
Street
City
State
Zip Code

Occupation: _____ Title: _____

Date of Employment: _____ Hours worked per week: _____

Are you actively at work? Yes No If "No" explain _____

Marital Status: Single Married Widowed Divorced

Reason for Enrollment (Please check appropriate boxes)

- I am an employee of an organization which is applying for coverage.
- I am now eligible for coverage and:
 - had no previous coverage during the past 90 days; or
 - had previous coverage during the past 90 days.

Name of previous carrier: _____ Plan # _____

- I previously refused and waived coverage
- I am applying for coverage during my organization's HMO open enrollment period. Open enrollment date: _____
- I am continuing coverage under state or federal law.
- I am adding/deleting dependents
- Other (specify) _____

SECTION II: COVERAGE INFORMATION

1. Persons to be covered: Employee Only Employee & Child(ren)
 Employee & Spouse Employee, Spouse & Child(ren)

2. Please provide all information for each person to be covered.

Full Name	Last,	First,	MI	Sex	Social Security #	Place of Birth	Date of Birth
Employee							
Spouse							
Child							
Child							
Child							
Child							

Indicate whether you and/or your spouse, if any, are enrolled under Part A and/or Part B of Medicare

	Plan A		Plan B		Medicare ID *
Employee	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Spouse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

4. PIP Selection Which coverage have you selected to provide benefits under the Personal Injury Protection (PIP) segment of your New Jersey auto insurance? Auto Medical

5. Name(s) of Primary Care Physician(s) _____

SECTION III: DECLARATION AND AUTHORIZATION

I hereby apply for the group coverage for which I am or may become entitled. I authorize deductions from my pay for my share of the cost, if any.

I represent to the best of my knowledge and belief, that the statements and answers given on this form are true and complete.

I understand that the information, other than any health information, shall form the basis upon which I may be included for coverage under the group plan.

I understand that:

a. the coverage applied for will not take effect unless:

- the first required contribution has been paid to the Association Master Trust.
- I am actively at work for full pay on a full time basis on the date coverage is to take effect.

b. no person, except an officer of Association Master Trust has authority to: determine whether any certificate shall be issued on the basis of this Enrollment Form; waive or modify any of the provisions of the Enrollment Form or any of Association Master Trust requirements; bind Association Master Trust by any statement or promise pertaining to any certificate signed or to be issued on the basis of this Enrollment form or accept any information or representation not contained in the written Enrollment Form.

c. the Employer is hereby designated as my representative for the purpose of receiving required contributions and remitting them to the Association Master Trust

Note: Any person who knowingly files a statement of claim, application for coverage, enrollment form containing any false or misleading information may be subject to criminal and civil penalties.

AUTHORIZATION

1. I authorize the sources stated below to give to the Association Master Trust or any consumer reporting agency or administrator acting on its behalf, information about me and my minor children, if applying for coverage. Such information will pertain to employment, insurance coverage and medical care, advice, treatment or supplies for any physical or mental condition.

Authorized sources are: any physician or medical professional, any hospital, clinic or other medical care institution; any insurer; the Medical Information Bureau; any consumer reporting agency or any employer.

2. I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which Association Master Trust has taken in reliance on the authorization.

3. I know that I have the right to receive a copy of this authorization if I request one.

(Date Signed)

(Signature of Employee)