



# Enrollment Form

BeniComp Inc.  
8310 Clinton Park Dr.,  
Ft. Wayne, IN 46825

(260) 482-7400 ■ 1-800-837-7400

This form must be either typed or printed. Illegible or incomplete forms will not be processed.  
Return both the white and yellow copies to BeniComp.

<b>EMPLOYEE</b>	Employer	Group Number	
	Division / Category	Effective Date Month / Day / Year	
	Employee Name	Employee Social Security Number	
	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Address	
	Date Employed Full Time Month / Day / Year	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
	Date of Birth Month / Day / Year	Work phone	Home Phone
	Hours Worked Weekly	Annual Salary	Occupation

### Coverage Status

Clearly check which coverages you are electing. List only those dependents to be covered.  
Note: You can only select dependents coverage(s) for the option for which you elect employee coverage.

			Life And AD&D	Dependent Life	Long Term DI	Short Term DI	Medical	Dental	Vision
Last Name	Spouse's First	Middle Initial	S.S. #	Sex	Date of Birth		Medical	Dental	Vision
Last Name	Spouse's First	Middle Initial	S.S. #	Sex	Date of Birth		Medical	Dental	Vision

### Certificates Of Prior Coverage

Did you or your dependents have other insurance coverage prior to this enrollment?  Yes  No You (and your family) will be subject to a pre-existing condition exclusion unless it can be established that you (and your family) have been covered by other insurance coverage for at least 12 months and have not experienced a "break in coverage" of 63 or more days. **To verify this prior coverage, please attach to this form any "Certificate of Prior Coverage" you have received.** If you have not received a Certificate, you should request it from your prior insurance carrier and forward it to BeniComp as soon as possible. You also have the opportunity to demonstrate credible coverage by providing other relevant data (such as pay stubs, EOB forms etc.)

### Other Medical Coverages

Is other medical coverage provided for any family members:  Yes  No (If "YES" list family member and type of coverage)

Name of Family Member	Type of Coverage	Insurance Company Name
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### Beneficiary Information

Beneficiary Name	Relationship	
Address	Contingent Beneficiary	

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

### Declination Of Coverage

Note: You must complete this section if you decline coverage for yourself (if single) or decline family coverage (if married).

I hereby acknowledge that I have coverage for myself and/or my family (if applicable) because I/we/they are covered under the following health plan:

Name of Family Member	Name of Insurer or Employer	Entity To Which Claims Are Submitted
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If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverages, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within thirty days (30) after your other coverage ends. In addition, if you have a new dependents 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 thirty (30) days after the marriage, birth, adoption or placement for adoption. However, if you fail to discuss any other health insurance you currently have, you (and your family) may not be eligible to enroll when that coverage is terminated.

Signature of employee \_\_\_\_\_ Date \_\_\_\_\_

### For BeniComp Internal Use Only

\_\_\_\_ Process Form  
\_\_\_\_ Update RX  
\_\_\_\_ Qualifying Event Generated

\_\_\_\_ Cobra/HIPPA Notice Sent  
\_\_\_\_ Lafayette Life Updated  
\_\_\_\_ HIPPA Only Sent

\_\_\_\_ ID Card Printed  
\_\_\_\_ Copy To Billing  
\_\_\_\_ Sent To Scanning