

ENROLLMENT / CHANGE CARD

NOTE: Please refer to the back of this document for important information regarding Pre-Existing Condition Exclusions.

ENROLLMENT REASON
 NEW ENROLLMENT
 CHANGE

(Check as applicable) PAYROLL DEDUCTION: EMPLOYEE DEPENDENT (For PAI use only) NO LOSS NO GAIN: EE DEP NONE

Employee Information	EMPLOYER: _____						GROUP #:						
	EMPLOYEE NAME: _____					SOCIAL SECURITY #:							
	ADDRESS: _____				CITY: _____		STATE: _____		ZIP CODE: _____				
	DATE OF BIRTH: _____			SEX: M <input type="checkbox"/> F <input type="checkbox"/>		MARITAL STATUS: SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>							
	DATE EMPLOYED: _____			COVERAGE EFFECTIVE DATE: _____			WAITING PERIOD (days): 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 <input type="checkbox"/>						
Healthcare Coverage	COVERAGE SELECTION			Medical		Dental		Vision					
	SINGLE			<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>					
	EMPLOYEE & SPOUSE			<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>					
	EMPLOYEE & <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3+ children			<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>					
FAMILY			<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>						
Life / Disability Coverage	<input type="checkbox"/> LIFE <input type="checkbox"/> DISABILITY POSITION/CLASS _____						EARNINGS: _____		<input type="checkbox"/> HOURLY				
	LIFE VOLUME _____						\$ _____		<input type="checkbox"/> ANNUALLY				
BENEFICIARY NAME _____						DISABILITY WEEKLY AMOUNT \$ _____							
RELATIONSHIP _____													
Dependent Information	Relationship		Last Name		Legal Name		M.I.		Social Security #		Date of Birth		Gender M / F
	SPOUSE												
	CHILD												
	CHILD												
	CHILD												
	CHILD												
	IF CHANGING COVERAGE, PLEASE LIST BELOW: <input type="checkbox"/> EFFECTIVE DATE OF CHANGE _____ <input type="checkbox"/> NAME CHANGE FROM _____ TO _____ <input type="checkbox"/> BENEFICIARY CHANGE TO: NAME _____ RELATIONSHIP _____ <input type="checkbox"/> SINGLE TO FAMILY (LIST ADDED DEPENDENTS ABOVE.) <input type="checkbox"/> FAMILY TO SINGLE (LIST DELETED DEPENDENTS ABOVE.) <input type="checkbox"/> ADD DEPENDENT(S) (LIST ABOVE.) <input type="checkbox"/> DELETE DEPENDENT(S) (LIST ABOVE.) <input type="checkbox"/> CHANGE LIFE VOLUME FROM _____ TO _____ DATE _____												
Other Coverage	Do you or does any member of your family have other group health, dental or drug coverage, Federal Employees' Program (FEP) or Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES: <input type="checkbox"/> MEDICARE A Effective Date _____ <input type="checkbox"/> MEDICARE B Effective Date _____												
	A. Family Member's Name _____ and Social Security # _____												
	B. Name of Insurance Co. _____ Policy # _____ Effective Date _____												
	C. Family Member's Employer _____												
	D. List Names of Covered Person(s) 1 _____ 2 _____ 3 _____ 4 _____												
E. Please check each type of service covered by the policy: Hospital Physician / Medical Prescription Drugs Dental Vision													

I HEREBY CERTIFY THAT I AM AN ACTIVE FULL-TIME EMPLOYEE. IT IS FURTHER UNDERSTOOD THAT THE ACCEPTANCE OF MY PREMIUM BY MY EMPLOYER AT ANY TIME SHALL NOT OPERATE AS A WAIVER OR ESTOPPEL WITH RESPECT TO ANY PROVISION OF THE GROUP CONTRACT, INCLUDING THE PROVISIONS CONCERNING ME OR MY DEPENDENTS' ELIGIBILITY. I HEREBY CERTIFY THAT THE FOREGOING STATEMENTS, INCLUDING ANY ACCOMPANYING STATEMENTS, ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I HEREBY AUTHORIZE ANY HEALTH PROVIDER OR MY EMPLOYER TO RELEASE ANY RECORDS OR INFORMATION TO PLANNED ADMINISTRATORS, INC. ON MYSELF OR DEPENDENTS. A COPY OF THIS RELEASE IS AS VALID AS THE ORIGINAL. I HEREBY AUTHORIZE MY EMPLOYER TO DEDUCT THE REQUIRED PREMIUM CONTRIBUTIONS, IF ANY, FROM MY PAYROLL EARNINGS.

Employee Signature _____ Date _____

SIGN BELOW IF YOU DO NOT ELECT TO BE COVERED

I HEREBY CERTIFY THAT I HAVE BEEN OFFERED AN OPPORTUNITY TO BECOME COVERED UNDER THE PLAN SPONSORED BY MY EMPLOYER AND I HAVE DECIDED NOT TO TAKE ADVANTAGE OF THIS OFFER.

Employee Signature _____ Date _____

PRE-EXISTING CONDITIONS EXCLUSIONARY PERIOD

This plan imposes a pre-existing condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days after birth, adoption or placement for adoption.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the preexisting condition exclusion and creditable coverage should be directed to Eligibility Department, Planned Administrators, Incorporated, P.O. Box 6927, Columbia, South Carolina 29260, or call us at: (800) 768-4375 or (803) 462-0151.