HARDING UNIVERSITY

MEDICAL & DENTAL ENROLLMENT FORM

Purpose of Application
- New Enrollee
- Add Dependent(s)
- Remove Dependent(s)
- Change Form
- COBRA
- Termination
- Late enrollee

Last Name	First Name	MI	Social Security Number	Date of Birth

Marital Status	Sex	Date of Hire	Medical/Dental Effective Date	Pre-X End Date	Group Info
Married Single	Male Female		(Employer's Use Only)	(Employer's Use Only)	Group # 20702 Plan # Division #

Street Address/PO Box	City	State	Zip	Phone Number

Type of Coverage	Special Enrollment Reasons	
Employee Only Employee Plus One Family	Marriage Birth Adoption/adoptive placement	Legal separation/divorce Death Termination/reduction in hours Spouse loss of coverage

Dependent Information

Add/ Remove	Full Name	Date of Birth *	Sex	Relationship To Employee	SS# of Dependent	Pre-X End Date

*** --** Dependents age 19 or older must provide proof of full-time student status

Other Coverage **Effective Date**________________ **Termination Date**____________________

Do you or any member of your family have other health/dental insurance? Yes No Medicare

If Yes, please indicate: Policy Holder ___________________________________ Policy Number ______________________

Carrier Name ___________________________________ Type of Coverage ____________________

Carrier Address ____

Proof of Creditable Coverage: Under the Health Insurance Portability and Accountability Act (HIPAA), individuals have the right to demonstrate prior health coverage to reduce the Plan's pre-existing condition exclusion period by providing Proof of Creditable Coverage. The Plan's pre-existing condition exclusion period will be reduced by a period equal to the period of any creditable coverage as long as there is no break in coverage of 63 days or more. Waiting periods are not considered a break in coverage. Proof of Creditable Coverage should be issued by your previous health plan administrator and should be submitted with this enrollment form when applying for coverage.

Authorization: I hereby authorize any health care provider, insurance company, the Medical Information Bureau, or other organization, institution, or person that has any information regarding claim or the facts contained herein to release to claims administrator any and all such information. A Photostat copy of this authorization shall be considered as effective and valid as the original. I understand that I have a right to receive a copy of this authorization upon request.

Acknowledgement: I acknowledge that the above referenced Employer Plan (the Plan) is entitled to recover from any person or firm legally responsible for my injuries up to the amount of benefits the Plan pays on my claim. I will not release any responsible party from liability without the Plan's written approval. I agree to reimburse the Plan to the extent of the amount paid on claims under any non-occupational benefit provision under any Workers' Compensation law or similar legislation.

☐ **No, I do not wish to enroll in this Plan,** although it has been made available. I understand that my dependents and I can enroll in the plan during a special enrollment period, or any other enrollment period as defined in the Plan Document.

My signature below affirms that all information and statements, provided on this form, are full, complete and true to the best of my knowledge. I understand that any misrepresentation of a material fact on this document may be cause for dismissal and may result in my coverage being void as of its effective date with no benefits payable.

Signature/Date ______________________________________/____/____ **Employer's Signature** ______________________