Maine Automobile Dealers Association Insurance Trust - GROUP # F500
HEALTH BENEFIT ENROLLMENT FORM

Employer Use Only

Date of Hire _____/_____/_____ Effective Date _____/_____/_____ Division_____

HIPAA Creditable Coverage Certificate Attached? _____ Dealership_____

PLEASE CHECK ONE: ☐Open Enrollment ☐New Employee ☐Re-hire date _____

I. GENERAL EMPLOYEE INFORMATION

Last Name	First Name	M.I.	Soc Sec #	Tel #

Mailing Address	City	State	Zip Code

Date of Birth	Sex ❒ M ❒ F	Occupation

II. MEDICAL ELECTION

Medical Plan Election	❒ **Plan A** $1,000 Deductible ❒ **Plan B** $1,500 Deductible ❒ **Plan C** $3,000 Deductible	Employee ❒	Employee/Child(ren) ❒	Family ❒

III. DENTAL ELECTION

Dental Plan Election	Employee ❒	Employee/Child(ren) ❒	Family ❒

IV. MEDICAL & DENTAL INSURANCE PARTICIPANT LISTING

Last Name	**First Name**	**Medical**	**Dental**	**Relation-ship**	**Social Security #**	**Sex**	**Date of Birth**	***Full-time Student? Yes**	**No**
Spouse									
Dependent									
Dependent									
Dependent									
Dependent									
Dependent									

*Please furnish us with the school(s) name that the dependent(s) attend full-time_____

V. EXISTING / PRIOR COVERAGE – Please provide front and back copy of ID card

Do you or your dependents have any other **Medical** coverage? **Yes** ❒ **No** ❒ If yes, please complete the following:
Do you or your dependents have any other **Dental** coverage? **Yes** ❒ **No** ❒ If yes, please complete the following:

Insurance Co. Name: *Telephone Number: ( )*	Address
Policy Holder	Policy #
Effective Date_____/_____/_____ End Date_____/_____/_____	Person(s) Covered ❒**Yourself** ❒ **Spouse** ❒ **Children**

Is anyone listed on this application currently eligible for Medicare?
Yes ❒ **No** ❒ If yes, please complete the following for each person eligible for Medicare.

Name(s)	Health Insurance claim no.	Medicare Part A effective date	Medicare Part B effective date	Medicare Part D effective date	Check all reasons that you qualify for Medicare		
					Age 65	Disability	ESRD

If you are enrolling in health coverage for the first time you may be able to avoid the pre-existing limitation by providing prior coverage information. If you have prior coverage, please attach a copy of the HIPAA certificate or other proof of prior coverage.

VI. DECLINATION OF COVERAGE / SPECIAL ENROLLMENT

Decline Coverage (I do not want coverage):	❒ Medical Coverage	❒ Dental Coverage	❒ Myself	❒ Dependents

_____ _____
Employee Signature Date

SPECIAL ENROLLMENT
If you are declining enrollment in the Plan for yourself or your dependents (including your spouse) because you and your dependents are covered under other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as 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 30 days after the marriage, birth, adoption or placement for adoption.

VII. SIGNATURE

I am requesting coverage for myself and all dependents listed on this form, and I authorize my employer to deduct any required contributions for this coverage from my earnings. All statements and answers I have given are true and complete. I understand that if I have provided any false, incomplete, or misleading information, then my coverage under this Plan may be null and void and may result in a denial of all benefits. I understand that all benefits are subject to the terms and conditions stated in the Plan Document. I authorize all health care providers, third party payers, utilization review agencies, my employer, and state or federal agencies to exchange all demographic, medical, mental health, AIDS and HIV, and substance abuse information with Anthem Blue Cross Blue Shield of Maine or its designees necessary for claims processing, clinical studies, care management, Plan administration, or benefit administration. I understand any information will be used only after issuance of Plan coverage and will have no effect on determination of eligibility to enroll. By accepting benefits under this Plan, a plan participant agrees to reimburse the Plan for benefits paid resulting from an accident or illness when a recovery has been received by the plan participant from a third party or insurer. The Plan is entitled to receive reimbursement equal to the amount of the recovery or payment up to the amount the Plan paid.

I give this consent for myself and any eligible family members listed on this application for whom I am authorized to do so. I understand that failure to sign this authorization may be a basis for enrollment or benefit denial. I understand that I am entitled to receive a copy of this authorization. I further understand that this authorization will remain in effect until coverage under this Plan ends or I give written notice to Anthem Blue Cross Blue Shield of Maine that I want to revoke this authorization. I understand that revocation of this authorization may be a basis for denying benefits.

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

NOTE: All family members 18 years of age and older, who are also enrolling at this time, must also sign this consent.

In signing this application I certify that: I have read and understand all the information on both sides of this form.

_____ _____
Employee Signature Date

_____ _____
Spouse Signature Date

_____ _____
Dependent(s) (18 Years and Older) Signature Date

Note: Please return completed form to:

Maine Automobile Dealers Association Insurance Trust
Attn: Membership Administration
180 Civic Center Drive
PO Box 2667
Augusta, ME 04338-2667 FAX # 207-623-2318
Rev. (8/10)