BAS Benefit Administrative Systems, LLC

GROUP ENROLLMENT FORM

Application For: ( ) NEW ENROLLEE ( ) LATE ENROLLEE ( ) SPECIAL ENROLLMENT ( ) CHANGE IN STATUS
DO YOU HAVE A CERTIFICATE OF COVERAGE? ( ) YES (if yes, please attach) ( ) NO

EMPLOYER NAME: **HMS Enterprises, Inc.**

NAME (Please Print) ____

ADDRESS ____

ADDRESS____

PHONE _______________ GENDER_________ SSN ______________________________

FOR EMPLOYER USE ONLY	
GROUP # **300261**	LOCATION # **0001**
HIRE DATE	EFFECTIVE DATE

DATE OF BIRTH________________________ MARITAL STATUS ( ) SINGLE ( ) WIDOWED ( ) MARRIED ( ) DIVORCED

COVERAGE LEVEL

MEDICAL COVERAGE LEVEL: ( ) SINGLE ( ) EMPLOYEE + SPOUSE ( ) EMPLOYEE + CHILD(REN) ( ) FAMILY

COVERED DEPENDENT INFORMATION

DEPENDENT	(M)	(F)	FIRST NAME	MI	LAST NAME	SSN#	DATE OF BIRTH
SPOUSE	[ ]	[ ]					
CHILD	[ ]	[ ]					
CHILD	[ ]	[ ]					
CHILD	[ ]	[ ]					
CHILD	[ ]	[ ]					
CHILD	[ ]	[ ]					

* If Your Spouse Or Children Have A Last Name Different From Yours, Provide A Marriage License And/Or Birth Certificate.
* If Your Dependent Child Is 19 or Older, Provide Full-Time Student or Disability Verification

Are You Or Any Of Your Dependents Covered By Another Group Medical Plan? [ ] Yes [ ] No
If "Yes", Please Give The Following Information:

Name of Individual with Other Coverage ______________________________ Effective Date: ______________

Names of Covered Dependents ____

Name of Insurance Carrier Or TPA ______________________________Phone: ________________

Address ____

Name of Other Employer Providing Coverage ____

Is Your Spouse Employed? ( ) Yes ( ) No If "Yes", Is Spouse Eligible for Employer Coverage? ( ) Yes ( ) No

Is there a divorce decree or court order requiring you to be financially responsible for medical coverage for dependent children?
( ) Yes ( ) No If "Yes", please provide a copy of the legal order.

SIGN AND DATE ENROLLMENT FORM ELECTIONS ABOVE

I have received and read a summary of the plan description. I certify that the above information is true and accurate.

EMPLOYEE SIGNATURE ______________________________________ DATE SIGNED ______________

BENEFIT WAIVER STATEMENT

I, the undersigned, certify that I have been given an opportunity to apply for the group benefit plan offered by the company and after careful consideration have decided to decline to enroll in the coverage(s) hereafter indicated.

ARE YOU DECLINING DUE TO COVERAGE IN ANOTHER PLAN [ ] YES [ ] NO

IF YES, IS THIS OTHER COVERAGE COBRA FROM A PRIOR EMPLOYER [ ] YES [ ] NO

IMPORTANT NOTICE: If you refuse coverage for yourself, you automatically refuse coverage for any dependents. If you are declining enrollment for yourself or your dependents (including your spouse) because of 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. Also, you must indicate the reason for declining enrollment to later be eligible under the special enrollment rules. 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. The pre-existing condition limitation is stated in the summary plan description. You and/or your dependents have the right to demonstrate creditable coverage by requesting a certificate of coverage from your prior plan or insurer. If necessary and requested, the plan will assist you in obtaining the certificate. I have received and read a summary of the plan description, and any amendments regarding the impact of HIPAA. I certify that the above information is true and accurate.

SIGNATURE OF EMPLOYEE ______________________________ DATE SIGNED ____________________