

AMERIBEN- HDHP- Buy-Up

1. EMPLOYEE INFORMATION TO BE COMPLETED BY THE EMPLOYEE ONLY

Social Security Number _____ Last Name _____ First Name _____ MI _____

Mailing Address _____ City _____ State _____ Zip Code _____

Marital Status Single Married Widowed Divorced Date of Birth ____/____/____ Sex Female Male Hours Worked Per Week _____

Address Change Name Change (previous name) _____ Telephone # Home (____) _____ Work (____) _____

I waive the following coverage(s) Medical Signature _____

If you are waiving medical coverage you must Sign and indicate your medical carrier. _____
If you are waiving Medical coverage you are automatically entitled to Life / AD&D and Short Term Disability

2. BENEFIT OPTIONS

- Employee Only
- Employee + Spouse
- Employee + Children
- Employee + Family

IS THIS A QUALIFYING EVENT? YES () NO () LIST THE EVENT AND DATE _____

3. LIST SPOUSE AND DEPENDENTS UNDER 26 TO BE COVERED ON THE PLAN

Last Name	First Name	MI	Social Security Number (Mandatory)	Relationship	M/F	DOB	ADD (X)	TERM (X)	OTHER INSURANCE
				Spouse					

4. OTHER INSURANCE INFORMATION MUST BE COMPLETED

Policy Holder _____ Carrier Name _____
Date of Birth of Policy Holder ____/____/____ Other Plan Policy Effective Date ____/____/____ / Policy Number _____
If anyone is currently on Medicare, please list information. ID Number _____ Part A Effective Date _____ Part B Effective Date _____

5. I hereby appoint my Employer as agent to receive all notices concerning premiums, coverage and termination and authorize my payroll deductions as required for coverage. I understand that any false or inaccurate information may result in the termination of coverage or non payment of benefits. I hereby authorize any provider of service to release to AmeriBen any information regarding diagnosis, treatment or prognosis for any person listed on this application.

SIGNATURE OF EMPLOYEE _____ DATE _____

6. TO BE COMPLETED BY HUMAN RESOURCES DEPARTMENT ONLY

New Hire Hire Date ____/____/____ Effective Date ____/____/____ Termination of Insurance ____/____/____

Change Effective Date of Change ____/____/____ Add/Term Dep(s) Qualifying Event _____

Rehire Rehire Date ____/____/____

Retiree Retiree Effective Date ____/____/____

Leave Of Absence Start Date ____/____/____

Salary \$ _____ HR Dept. Initials _____ Date _____