NORTH AMERICAN DIVISION BENEFITS
Healthcare

2015 | EMPLOYEE HEALTHCARE LEGACY ENROLLMENT APPLICATION

EMPLOYEE INSTRUCTIONS:
Complete the entire application except the employer section of this page. Return your completed application within five days to your employer. Benefits will be withheld until application is received.
Only add people you want to add to the plan

EMPLOYEE INFORMATION:

GROUP# 6LGP707800 | DEPT# 6304N | DEPARTMENT: | HIRE DATE: (MM/DD/YYYY) | EFFECTIVE DATE: (MM/DD/YYYY)

EMPLOYER: Southeastern CA Conference of SDA | EMPLOYEE'S E-MAIL ADDRESS:

FIRST NAME: | M.I. | LAST NAME:

SSN# | SEX: ☐ M ☐ F | BIRTHDATE: | MARITAL STATUS: ☐ SINGLE ☐ MARRIED

ADDRESS 1:

ADDRESS 2: | WORK PHONE:

CITY: | STATE: | ZIP CODE: | HOME PHONE:

PREVIOUS EMPLOYER:

SPOUSE INFORMATION:

FIRST NAME: | M.I. | LAST NAME:

BIRTHDATE: (MM/DD/YYYY) | SEX: ☐ M ☐ F | SSN# | EMPLOYED: ☐ YES ☐ NO | SPOUSE EMPLOYER:

OTHER INSURANCE: ☐ YES ☐ NO | DEPENDANTS COVERED? ☐ YES ☐ NO | SPOUSE EMPLOYER PHONE#

NAME OF INSURANCE: | POLICY HOLDER ID #: | EFFECTIVE DATE: (MM/DD/YYYY)

THIS OTHER INSURANCE IS: ☐ PRIMARY ☐ SECONDARY | E-MAIL ADDRESS:

DEPENDANT INFORMATION:

RELATIONSHIP	FIRST NAME	M.I.	LAST NAME	BIRTHDATE (MM/DD/YYYY)	OTHER INSURANCE YES / NO	OTHER INSURANCE PRIMARY / SECONDARY	DEPENDANT'S SSN#
☐ SON ☐ DAUGHTER					-	-	
☐ SON ☐ DAUGHTER					-	-	
☐ SON ☐ DAUGHTER					-	-	
☐ SON ☐ DAUGHTER					-	-	

PLAN COVERAGE SELECTION

EMPLOYEE ONLY ☐ | EMPLOYEE & CHILD (REN) ☐ | EMPLOYEE + SPOUSE ☐ | FAMILY ☐

EMPLOYEE AUTHORIZATION AND CERTIFICATION

I authorize all providers of health care to furnish all records pertaining to medical history, services and rendered treatment given as pertains to evaluation of enrollment application and/or claims. This authorization will become effective immediately and will remain in effect as long as necessary to enable Adventist Risk Management Inc to process the application and/or claims.

I agree to notify my employer of any changes in family status or eligibility of family members. Failure to notify my employer of any status changes will authorize my employer to ask Adventist Risk Management Inc to deny payments of future claims and ask for collection of past paid claims for ineligible spouse or dependents.

I certify that all of the above information is complete and correct.

EMPLOYEE SIGNATURE: | DATE (MM/DD/YYYY):

OFFICE USE ONLY

EMPLOYER INSTRUCTIONS TO BENEFIT PLAN ADMINISTRATORS:

NAME	EFFECTIVE DATE (MM/DD/YYYY)	Use (P) for PRIMARY and (S) for SECONDARY			
		MEDICAL	DENTAL	VISION	RX
EMPLOYEE:					
SPOUSE:					
DEPENDANT CHILD #1:					
DEPENDANT CHILD #2:					
DEPENDANT CHILD #3:					
DEPENDANT CHILD #4:					

RECEIVED ON:

HEALTHSCOPE

VERIFIED ☐ HEALTHSCOPE ☐ RX

FOR ARM OFFICE USE ONLY

OFFICE USE ONLY

COMMENTS:

EMPLOYER SIGNATURE*:

DATE (MM/DD/YYYY):

SIGNATORY'S NAME:

COVERAGE CODE:

SIGNATORY'S TITLE:

***Please enter your initials to serve as your digital signature.**

By entering your initials and sending this form attached to an e-mail from your e-mail account, we will consider this form signed by you.

This form can be submitted electronically to: HEALTHCAREELIGIBILITY@adventistrisk.org

(You **must** save the document to your computer then attach it to the e-mail generated by the link above)