TR Paul Inc.

ENROLLMENT AND WAIVER FORM

☐ **New Enrollment**
☐ **Open Enrollment**
☐ **Enrollment Change effective on** _____
☐ **Special Enrollment**
☐ **Late Enrollment**

14 COMMERCE ROAD
P. O. BOX 5508
NEWTOWN, CONNECTICUT 06470-5508

WE ARE YOUR THIRD PARTY ADMINISTRATOR
Phone: (800) 678-8161
Fax: (203) 270-0927

EMPLOYER

Shaded Areas for TR Paul Use Only

(Please Print)

Name of Employee Last Name First Name MI

Address Number Street Apt #

City State Zip Code

☐ Female ☐ Male	IDENTIFICATION NUMBER	DATE OF BIRTH Month	Day	Year	ANNUAL SALARY	SOCIAL SECURITY NUMBER / /	☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

Note: You *must take* all coverages offered by your employer for which your employer pays full cost. You *may elect* any or all coverages offered by your employer for which you pay a portion of the cost.

I AM ENROLLING IN:	YES	NO**	VOLUME	BENEFIT CLASS	I AM ENROLLING IN:	EMPLOYEE	DEPENDENT	NO
Group Life and AD&D					Medical			
Supplemental Life					Prescription			
Dependent Life					Dental			
Weekly Income (STD)					Vision			
Long-Term Disability								

LOCATION	EFFECTIVE DATE OF COVERAGE Month	Day	Year	JOB TITLE	HOURS WORKED PER WEEK FOR THIS EMPLOYER	DATE OF FULL TIME EMPLOYEMENT Month	Day	Year

MY BENEFICIARY IS: First Name MI Last Name RELATIONSHIP

CONTINGENT BENEFICIARY (IES): If more than one named, the beneficiaries shall share equally unless otherwise stated below.

DO YOU HAVE PRIOR CREDITABLE COVERAGE?

☐ YES ☐ NO

IF YES, ATTACH PROOF

LIST BELOW ALL ELIGIBLE DEPENDENTS INCLUDING SPOUSE

Name of Dependent	Date of Birth	Social Security Number	Relationship

SPOUSE'S INFORMATION

Name of Employer:

Address of Employer:

Medical Insurance? ☐ Yes ☐ No
Carrier:

Dental Insurance? ☐ Yes ☐ No
Carrier:

**** WAIVER OF BENEFITS** ☐ (Check here if waiving any coverage other than medical or dental)

I have been given the opportunity to participate in all of the coverages for which I am eligible which are offered by my company's Group Benefit Plan and have declined certain coverages as indicated above. If at a later date I wish to apply for previously waived coverages (other than medical coverage), I understand that before I can be covered, I may, at my own expense, be required to furnish evidence of insurability which is satisfactory to the Insurance Company and my Employer.

I hereby authorize the Employer to make any required deductions from my wage or salary for the cost of the benefits in which I have enrolled.

I authorize any physician, medical practitioner, hospital, clinic or other medically related facility, insurance or reinsurance company, or employer having information available as a diagnosis, treatment or prognosis with respect to any physical or mental condition and/or treatment of me or my dependents and any other non-medical information of me or my dependents to give to the group policyholder, my employer, TR Paul Inc. or its legal representative any and all such information.

I understand the information obtained by use of the authorization will be used by TR Paul Inc. to determine eligibility for insurance and benefits under an existing policy. Any information obtained will not be released by TR Paul Inc. to any person or organization EXCEPT to the group policyholder, my employer, reinsuring companies or other persons or organizations performing business or legal services in connection with a claim, or as may be lawfully required or as I may further authorize.

_____ _____

EMPLOYEE SIGNATURE **DATE OF SIGNATURE**

_____ _____

REVIEWED BY COMPANY ADMINISTRATOR **DATE**

REMARKS:

TO THE ENROLLEE:

You have been given the opportunity to participate in all of the coverages for which you are eligible under your company's Group Benefit Plan.

SPECIAL ENROLLMENT

If you are declining enrollment for medical benefits for yourself or your dependents (including your spouse) because you or your dependents have 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 in this plan provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

The employer may require that you provide evidence that you are eligible to enroll in this plan under the plan's Special Enrollment provisions.

PRE-EXISTING CONDITION LIMITATION

If you are enrolling in the Group Health Plan and the plan contains a pre-existing exclusion, this exclusion period can be reduced by the number of days of your prior creditable coverage. Creditable coverage can include prior coverage under another group health plan, an organization, a state health benefits risk pool, any public health plan, or a health plan issued under the Peace Corps Act.

When applying prior creditable coverage to the plan's pre-existing condition limitation, the plan is not required to take into account any days of creditable coverage that precede a break in coverage of 63 days or more.

To determine if any of the plan's pre-existing condition limitation will apply to you, you must present proof of prior creditable coverage (a certificate or certificates of creditable coverage) to your employer. You may request a certificate of creditable coverage from a previous employer, insurance company or Health Maintenance Organization (HMO). If necessary, your employer will assist you in obtaining a certificate from any of these entities.

You may obtain specific information regarding the length of you plan's pre-existing condition exclusion from your employer.

PLEASE ATTACH PROOF OF PRIOR CREDITABLE COVERAGE TO YOUR ENROLLMENT FORM.