Election Form

Please return your completed registration forms to True Benefits Administrators or your HR office no later than 30 days from your eligibility date to ensure you receive benefits and cards in a timely manner.

	First Name / Last Name	DOB	M/F	SSN	Height	Weight
Employee						
Spouse						
Child						
Child						
Child						
Child						
Child						
Child						

Demographics:

First Name		Middle Initial:
Last Name		
Home/Cell Phone Number	Work Phone #:	
Home Address		
City, State, Zip		
Email Address		
Married/Single/Divorced/Widowed		
Full-time / Part-time Employment	# Hours Per Week:	
Corporation, LLC, or Entity Name		
Date of Hire	Tax ID:	Annual Salary:
Benefits Effective Date		(1st of Month following 30 days of Employment or 30 days from Change of Status for eligibility)
Beneficiary Name and Relationship		
Prior Carrier:	Start Date:	End Date:

Elections: Complete ALL boxes below or check this box to **Waive All Benefits** ☐ and skip to the next section.

Medical Plan Selection: ☐ Plan 1 / Base Plan (with Supplemental Accident) ☐ Plan 2 / Buy-Up Plan (with Supplemental Accident) ☐ Plan 3 / H.S.A. Plan (with Supplemental Accident) ☐ Waive Coverage	Medical ☐ Member Only ☐ Member with Spouse ☐ Member with Child(ren) ☐ Member with Family ☐ Waive Coverage
Dental ☐ Member Only ☐ Member with Spouse ☐ Member with Child(ren) ☐ Member with Family ☐ Waive Coverage	Vision ☐ Member Only ☐ Member with Spouse ☐ Member with Child(ren) ☐ Member with Family ☐ Waive Coverage
*Supplemental ☐ Member Only ☐ Member with Spouse ☐ Member with Child(ren) ☐ Member with Family ☐ Waive Coverage	☐ Accident (Buy Up for additional Accident benefits) ☐ Cancer ☐ Critical Illness ☐ Gap Coverage ☐ Hospital Protection ☐ Individual Life Insurance ☐ Short Term Disability

*****_Supplemental Policies each have health questions and underwriting prior to policy issue. These are not guaranteed issue policies. You will receive brochures, rates, applications, or forms for your signature from your Employee Liaison._ ***Your Employee Liaison 972-724-8900 Ext.111***

Questions: (Please do not leave any questions unanswered.)

☐ Yes ☐ No 1. In the last 2 years, have you or any dependent requesting coverage, used tobacco products?

☐ Yes ☐ No 2. Are you or any dependents to be covered not actively at work due to injury or illness, or are there any material or substantial job duties they are currently unable to perform due to sickness, maternity, or injury?
If #2 is "Yes", please list individual(s) name:____

☐ Yes ☐ No 3. Will this insurance replace any accident and sickness insurance currently in force with another company for any person to be insured? (This is not referring to health insurance, but separate supplemental insurance plans.)

☐ Yes ☐ No 4. Do you own any other accident, hospital indemnity and/or disability insurance which is not being ended (not including Worker's Compensation)?

☐ Yes ☐ No 5. Within the past 5 years, have you or any person applying for coverage been convicted of a felony, reckless driving, or driving under the influence of drugs or alcohol? If "Yes", the named individual(s) is not eligible for WNIC Supplemental Accident coverage.
If #5 is "Yes", please list individual(s) name:____

☐ Yes ☐ No 6. Does the primary member/enrollee work a minimum of 30 hours per week on average?

☐ Yes ☐ No 7. Whether you chose to elect any other services at this time, or not; did your marketing representative or enroller provide information regarding your other benefits in addition to health insurance?

ASO participants: You should have received information regarding any included payroll or compliance services, gym memberships, and other member benefits for which you are eligible through your CPR ASO membership – some at no additional charge to you – some available stand-alone without the insurance. For more information on how to access your additional membership benefits, please visit www.cpr-aso.com.

Please fill in any additional question or comment here:

Whether enrolling in the packages containing insurance products by phone, internet, or paper forms, you are agreeing to the following:

1) ***I understand that medical coverage is being provided by Aetna Life Insurance Company.***
2) ***The plan documents (Schedule of Benefits, Group Agreement, Group Policy and Certificate of Coverage) will determine my rights and responsibilities and will govern even if they conflict with any benefits comparisons, summary or other description of the plan.***
3) ***I understand and agree that with the exception of Aetna Rx Home Delivery*, all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. The availability of any particular product cannot be guaranteed, and provider network composition is subject to change.***

NOTICE: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or who conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Authorization: I agree the completed information above is accurate and true to the best of my knowledge. I understand my payroll deductions will be pre-taxed when applicable under Sec.125 rules for my location. I authorize the insurance plan or its representatives to obtain medical information and records for the members listed above in order to evaluate the information provided herein and future claims. This authorization is valid for 24 months following the date signed below.

Signature____ Date ____________________