Lifetime BENEFIT SOLUTIONS

GROUP BENEFIT PLAN ENROLLMENT FORM

LAST NAME: _____

FIRST NAME: _____

MIDDLE INITIAL: _____ **SUFFIX** _____ **SEX:** ☐ **MALE** ☐ **FEMALE**

Social Security #: _____-_____-_____

DATE OF BIRTH: _____/_____/_____ **DATE OF HIRE:** _____/_____/_____

HIPAA CERTIFICATE ☐ ATTACHED ☐ NO PRIOR COVERAGE ☐ PENDING ☐ LIFETIME BENEFIT SOLUTIONS

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ LEGALLY SEPARATED ☐ SIGNIFICANT OTHER

SPOUSES DATE OF BIRTH: _____/_____/_____

ADDRESS:

_____
STREET

_____
CITY, STATE, ZIP

_____
COUNTY

(_____) _____ - _____ **HOME PHONE**

(_____) _____ - _____ **BUSINESS PHONE**

CURRENT PRIMARY PROVIDER: _____

Provider Address: _____

☐ ACTIVE (FT) ☐ ACTIVE (PT) ☐ COBRA

☐ RETIRED WITHOUT MEDICARE ☐ RETIRED WITH MEDICARE:

"PART A" EFFECTIVE DATE: _____/_____/_____

"PART B" EFFECTIVE DATE: _____/_____/_____

"PART D" EFFECTIVE DATE: _____/_____/_____

FOR EMPLOYER USE ONLY

EFFECTIVE DATE: _____/_____/_____

EMPLOYER NAME: _____

DEPARTMENT/DIVISION: _____

STATUS: _____ **PLAN:** _____

OTHER CLASSIFICATION, IF APPLICABLE: _____

LIFE/LTD/STD CLASSIFICATION, IF APPLICABLE: _____

TYPE OF COVERAGE CHECK COVERAGES ONLY IF APPLICABLE	**MEDICAL** BLUE PPO-1	**MEDICAL** SIGNATURE HDHP-$1350	**MEDICAL** SIGNATURE HDHP-$5000	**N/A**
EMPLOYEE ONLY	☐	☐	☐	☐
EMPLOYEE + SPOUSE	☐	☐	☐	☐
EMPLOYEE + CHILD	☐	☐	☐	☐
EMPLOYEE + CHILDREN	☐	☐	☐	☐
EMPLOYEE & FAMILY	☐	☐	☐	☐
NO COVERAGE* (SEE SECTION BELOW)	☐	☐	☐	☐

*☐ I decline/waive the coverage available to:

☐ Myself ☐ Spouse ☐ Children, because:

☐ My dependents and/or myself are under another policy/group plan

EMPLOYER NAME: _____

CARRIER NAME: _____

OTHER REASONS: _____

DO YOU HAVE OTHER HEALTH COVERAGE: ☐ **Yes** ☐ **No** _____ _____
IF YES, NAME OF POLICY HOLDER POLICY NUMBER

_____ _____ (____) _____ - _____
OTHER CARRIER NAME CITY, STATE, ZIP PHONE

EFFECTIVE DATE OF MEDICAL COVERAGE: _____/_____/_____ EFFECTIVE DATE OF DENTAL COVERAGE: _____/_____/_____

TYPE: ☐ FAMILY ☐ SINGLE COVERAGE: ☐ MEDICAL ☐ DENTAL ☐ VISION ☐ RX

ARE YOU OR YOUR SPOUSE ENROLLED IN AN IRS-QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN WITH A HEALTH SAVINGS ACOUNT (HSA)? ☐ YES ☐ NO

Lifetime BENEFIT SOLUTIONS

GROUP BENEFIT PLAN ENROLLMENT FORM

SPOUSE INFORMATION (MUST BE COMPLETED IF APPLICABLE)

_____ ____ ____/____/____ _____-____-_____

LAST NAME, FIRST NAME, MI | SEX | DATE OF BIRTH | SOCIAL SECURITY NUMBER

SPOUSE'S COVERAGE:

CURRENT PRIMARY PROVIDER:_____

PRIMARY PROVIDER ADDRESS:_____

MEDICARE ELIGIBLE? ☐ YES ☐ NO

"PART A" EFFECTIVE DATE: ____/____/____

"PART B" EFFECTIVE DATE: ____/____/____

"PART D" EFFECTIVE DATE: ____/____/____

IF UNDER AGE 65, PLEASE PROVIDE REASON ON MEDICARE:

_____

IS SPOUSE EMPLOYED? ☐ YES ☐ NO

ENROLLED IN GROUP HEALTH PLAN? ☐ YES ☐ NO

TYPE OF COVERAGE: ☐ SINGLE ☐ FAMILY (IF FAMILY COVERAGE, PLEASE CHECK DEPENDENTS COVERED UNDER SPOUSE PLAN BELOW – SEE **)

☐ MEDICAL ☐ DENTAL ☐ VISION ☐ PRESCRIPTION

EFFECTIVE DATE OF MEDICAL COVERAGE: ____/____/____

EFFECTIVE DATE OF DENTAL COVERAGE: ____/____/____

DOES SPOUSE HAVE OTHER HEALTH COVERAGE :

_____ _____

CARRIER NAME | POLICY NUMBER

_____ (_____) _____ - _____

STREET ADDRESS | PHONE

_____

CITY, STATE, ZIP

CHILD(REN) INFORMATION

Last Name, First Name, MI	Sex	Relationship	Date of Birth	Social Security Number	**	School/College City, State	Enrolled Semesters	Disabled Y	Disabled N
			___/___/___	___-___-___	☐			☐	☐
			___/___/___	___-___-___	☐			☐	☐
			___/___/___	___-___-___	☐			☐	☐
			___/___/___	___-___-___	☐			☐	☐
			___/___/___	___-___-___	☐			☐	☐

I authorize payment of benefits to any doctor, physician or other provider for service that he/she may render to me or my family. I certify that all the above information is correct to the best of my knowledge. I desire to participate in the group medical program.

Under federal law it is a crime to knowingly and willfully make a false statement in connection with the delivery or payment for health care benefits or services (18 USC SEC. 1035). It is also a federal crime to attempt to defraud a health program or to knowingly and willfully steal or otherwise convert money from a health care fund (18 USC SEC. 669 and 18 USC SEC. 1347). These crimes are punishable by a fine or imprisonment or both.

_____ _____

SIGNATURE | DATE

For Lifetime Benefit Solutions Use Only:_____

Doing business as LBS Administrators and Flexible Benefit Insurance Solutions in California. Doing business as LBS Administrators in New Hampshire.