USABLE MUTUAL INSURANCE COMPANY

USABLE Mutual Insurance Company
P.O. Box 1151
320 W. Capitol – Ste. 800
Little Rock, AR 72203-1151

GROUP EMPLOYEE APPLICATION

Please fill in blanks below in ink.

Group No.: _____ **I.D. No.:** _____

Employer: _____

Group Administrator Use Only

Multiple Plan Option:

_____

Is the Employee waiving coverage in the plan? ☐ Yes ☐ No If yes, complete Sections 2, 6 & 9 only.

FOR OFFICE USE ONLY

Date of Full-Time Employment	☐ COBRA Effective Date	☐ COBRA Termination Date	Reason for COBRA:
Mo / Day / Year	Mo / Day / Year	Mo / Day / Year	_____

Are you a current, active employee? ☐ Yes ☐ No If no, retirement date: _____

SECTION 1. POLICY ELIGIBILITY

Check all applicable boxes below that support your eligibility, provide date of qualifying life event and documentation.

	Date		Date
☐ 1-Annual Open Enrollment Period			
☐ 2-New Enrollee		☐ 6-Marriage	_____
☐ 3-New Enrollee-Life Only (Omit Section 7)		☐ 7-New Adoption	_____
		☐ 8-New Guardianship/Legal custody/Court order to add child	_____
☐ 4-Loss of Minimum Essential Coverage	_____	☐ 9-Other: Reason _____	_____
☐ 5-Newborn	_____	_____	

NOTE: If Application is **not** received during Open Enrollment Period, please provide appropriate documentation with this Application to confirm qualifying life event/special election period (e.g. copy of marriage license, Certificate of Creditable Coverage from previous insurance company, legal guardianship/custody documentation, etc.).

SECTION 2. WHO IS APPLYING

Complete this section on all members to be covered or waived.
NOTE: Dependents of small groups (50 or fewer employees) are not required to complete this section if waiving coverage.

Coverage Desired: ☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Employee, Spouse & Child(ren)

Please indicate whether dependent children are natural, step or adopted.

First Name	M.I.	Last Name	Relationship	Sex	Date of Birth	Social Security No.	Waiving (✓)	$Amt Deductible Credit Submitted*	Primary Care Physician	PCP Number (NPI#)	Was This Your Regular Physician?
			Self								Yes/No
											Yes/No
											Yes/No
											Yes/No
											Yes/No
											Yes/No

*Deductible Credit is available for new group enrollments but only if the individual requests it on this initial application.

SECTION 3. MARITAL STATUS

☐ Single (including widowed or divorced) ☐ Married (including separated)

SECTION 4. CONTACT INFORMATION

Street or P.O. Box _____ City _____ State _____ Zip _____

Primary Phone Number( )_____ Work Phone Number( )_____ E-mail Address _____

SECTION 5. EMPLOYMENT STATUS

Job Title _____

☐ Hourly Hours Worked Weekly_____

☐ Salaried ☐ Other

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C/T	PKG	LIFE
EFF DATE	UND	DATE
OTH		

SECTION 6. WAIVER OF ENROLLMENT

To be completed if coverage is declined or refused by an eligible employee and/or their eligible family members.

1. Medical Coverage Declined For:			
☐ Myself ☐ Spouse ☐ Dependents	☐ Covered by spouse's group coverage – Carrier Name and ID:		
	☐ Enrolled in other Insurance Carrier Plans – Carrier Name and ID:		
	☐ Medicare	☐ Medicaid	☐ Covered by TRICARE or CHAMPVA
	☐ Other (Explain):		

I hereby certify that: (1) I have been given the opportunity to apply for the coverage made available through my employer under the applicable policy. The coverages and the policy have been thoroughly explained to me, and I decline to apply for coverage for myself and/or my dependent(s) as listed above; and (2) I understand that if I refuse to apply now and I apply for coverage at a later date, I will be deferred until open enrollment.

SECTION 7. CURRENT/PREVIOUS INSURANCE INFORMATION

(This section must be completed to process your enrollment application.)

For previous or continuing coverage please complete the following:
(If covered by more than one insurance plan, use additional paper)

Name of Insurer	Address	Phone
Policyholder Name	Date of Birth	Member ID#

List the following information for all family members covered by this policy (indicate those not residing in your household with a check ✓ mark)

First Name	Last Name	Relationship	✓	Eff. Date of Coverage	End Date of Coverage

For members listed above, are you responsible for providing primary health insurance coverage? ☐ Yes ☐ No
If no, please name responsible party: _____

☐ **Yes** ☐ **No** On the day coverage begins will any family members be covered by **Medicare**?
If yes, answer all questions below. (Use additional paper if necessary)

If yes, complete the following:
Reason for Medicare coverage: ☐ Over 65 ☐ Disabled ☐ Kidney Disease

Medicare Beneficiary Name:	Relationship of Beneficiary to Policyholder:

Medicare Health Identification Contract (HIC) Number:

Type of Medicare Coverage (check all that apply) ☐ Medicare Part A – Effective Date: ☐ Medicare Part B – Effective Date:

SECTION 8. LIFE INSURANCE (if purchased by your employer)

I hereby designate the beneficiary or beneficiaries listed below under this certificate and revoke the appointment of any existing beneficiary.

First Name	M.I.	Last Name	Date of Birth	Relationship

SECTION 9. SIGNATURES (PLEASE READ BEFORE SIGNING IN INK.)

I understand that the benefits for which I (we) will be eligible are those described in the USABLE Mutual Insurance Company policies with my employer as may from time to time be amended. I understand that coverage will not become effective before the approved effective date.

In signing this application, I represent that the statements and answers given in this application are true, complete and correctly recorded. I understand that USABLE Mutual Insurance Company may, within three years of the date of this application, void or terminate this coverage or deny claims for coverage if fraud or intentional misrepresentation of material fact has been given on this application. If fraudulent misstatements were made, USABLE Mutual Insurance Company may take legal action at any time.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Print Name of Applicant (Employee)	Signature of Applicant (Employee)	Date
Print Employer/Group Representative*	Signature Employer/Group Representative*	Date

**Required for new hires and additions only.*