

EMPLOYEE

Apex Management Group MEC Enrollment Application



Enrollee Information (All information must be completed to ensure coverage)					
Last Name		First Name		MI	
Date of Birth	Social Security #		Gender	Marital Status	
Date of Hire	<input type="checkbox"/> Part Time	<input type="checkbox"/> Full Time	Height	Weight	
Address Line 1		Address Line 2			
City	State	ZIP	Employer		
Phone	Email				
Coverage & Change Request Information (You may be required to provide proof of the event)					
Insurance Requested: <input type="checkbox"/> New Enrollment <input type="checkbox"/> Status Change					
Coverage level: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Child(ren) <input type="checkbox"/> Employee & Family					
Plan name: <input type="checkbox"/> MEC					
If changing plans, indicate Qualifying Event: <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Adoption <input type="checkbox"/> Returning to School Full-Time <input type="checkbox"/> Court Order <input type="checkbox"/> Other (specify): _____ Date of Qualifying Event _____					
Are you currently actively at work and able to perform the duties of your occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No					
How many hours are you regularly working per week with your current employer? _____ Hours per week					
Family Information (Only for those applying for coverage)					
First Name & MI (Last if different than employee)	Social Security #	Gender	Height	Weight	Date of Birth
Spouse					
Child					
Child					
Child					
Employee Agreement (Signature required)					
I authorize my employer to deduct the necessary contributions toward the benefits I have selected on a pre-tax basis from my pay. I understand that I cannot change the benefits I have selected or revoke this pay deduction authorization before the beginning of the next plan year unless that change or revocation is made on account of, and corresponds with, a change in status, a special enrollment event, or any other event that permits a mid-year change or revocation of elections under the terms of my employer's Section 125 cafeteria plan.					
Employee Signature			Date		
If signed by a representative of enrollee, please indicate the representative's authority to act on behalf of enrollee:					
Waiver (Only complete this section if you are waiving all coverage)					
I am declining coverage for (check <u>all</u> that apply): <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)					
I am declining coverage for the following reason(s): (Check <u>all</u> that apply and note that if you are declining coverage because you have other coverage, you must indicate that on this form. Failure to do so may result in you not being able to exercise special enrollment rights if you lose other coverage).					
<input type="checkbox"/> Covered by a spouse's or parent's group health plan <input type="checkbox"/> Individual medical plan <input type="checkbox"/> Not Affordable					
<input type="checkbox"/> COBRA/State Continuation <input type="checkbox"/> Government Plan (please specify plan name): _____					
<input type="checkbox"/> Other reason: _____					
I understand that this waiver may be reported to IRS informing them I have declined the Employer-provided healthcare plan and this may result in fines and repayment of any federal subsidies when selecting insurance through a Health Care Exchange.					
Authorization: As an employee, I hereby apply for, or waive (if indicated), group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary.					
Employee Signature			Date		