Manpower Associates Insurance Enrollment Form 2018

KEY BENEFIT ADMINISTRATORS

TRANSAMERICA®

1. Employee Information (Please complete all fields)

Group Name: D Mark Group dba. Manpower (M0001023)		Location: ☐ WI/MN ☐ Iowa ☐ Florida	
Social Security Number:		Gender: ☐ Male ☐ Female	
First Name:		Last Name:	
Mailing Address:			
City:		State:	Zip Code:
Date of Birth:	Date of Hire:	Cell Phone:	Home Phone:
Hour Worked/Week:		E-mail Address:	
Beneficiary Name:		Relationship:	

2. Plan Selection (Please check coverage requested)

MEC	MEC + Dental	MEC Preferred	MEC Preferred + Dental	Dental Only	Waive All Products
☐	☐	☐	☐	☐	☐

3. Please indicate who you are covering

Employee Only	Employee & Spouse	Employee & Child(ren)	Family
☐	☐	☐	☐

4. Dependent Information (Please complete for all dependents being covered)

Last Name:	First Name:	SSN:	Date of Birth:	Gender:	Relationship:
Last Name:	First Name:	SSN:	Date of Birth:	Gender:	Relationship: ☐ Spouse ☐ Child
Last Name:	First Name:	SSN:	Date of Birth:	Gender:	Relationship: ☐ Spouse ☐ Child
Last Name:	First Name:	SSN:	Date of Birth:	Gender:	Relationship: ☐ Spouse ☐ Child
Last Name:	First Name:	SSN:	Date of Birth:	Gender:	Relationship: ☐ Spouse ☐ Child
Last Name:	First Name:	SSN:	Date of Birth:	Gender:	Relationship: ☐ Spouse ☐ Child

5. Eligibility Questions (Please complete all questions)

a. Are you actively at work on a full-time basis and able to perform the regular duties of your occupation? If "No", you and your dependents are not eligible for coverage.	☐ Yes ☐ No
b. If applying for dependent coverage, is any proposed insured disabled? If "Yes", List Names_____, who will be excluded from MEC Preferred and Dental coverage.	☐ Yes ☐ No
c. For residents of all states, excepts AZ, CO, KS, KY, NC, OR, SC or VA: Is anyone proposed for coverage covered by Title XIX (Medicaid)? If "Yes", List Names_____, who will be excluded from MEC Preferred and Dental coverage.	☐ Yes ☐ No

I hereby apply for participation in my Minimum Essential Coverage Benefit Plan for myself and/or my dependents listed above and agree to abide by the terms, provisions and limitations as outlined by the Plan Sponsor in issuance of the Summary Plan Description. I declare all statements contained in this form are true and correct and that no material information has been withheld or ommitted. I agree that no benefits will be effective unti the date specified by Key Benefit Adminstrators. I authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, the Veteran Adminstration, or any other organization, instiution, insurance or reinsurance company, to disclose and release any information in its possession about the medical history, mental or physcial condition or treatments of myself and/or my dependents to Key Benefit Administrators, Inc. or its designee. This authorization includes information about drug abuse, alcoholism or mental illness. I agree a photographic copy of this authorization shall be as valid as the original and that said authorization shall be valid for the maximum lengt h of time permitted by law. I understand that I have the right to receive a copy of this authorization upon request. I authorize my employer to deduct from earnings the contributions (if any) required toward the benefits.

I understand that this enrollment application is for Minimal Essential Coverage/MEC Preferred as defined by the ACA and is not a Major Medical Plan

Name (Print): _____ Employee Signature: _____ Date: _____