INSURANCE MANAGEMENT SERVICES
P.O. Box 15688 • Amarillo, TX 79105

Group Health Insurance Enrollment Form

Employee Information:

Name: _____

Address: _____

City, State, Zip: _____

Birth Date: _____ Marital Status: _____

SSN: _____ Sex: _____

Email: _____

Phone: _____

Are you covered by any other insurance, including Medicare? _____

If so please fill out the following information:

Insurance Carrier Name: _____

Policy Number: _____

Phone Number: _____

Employment Information: (To be completed by employer)

Group Name: _____

IMS Group Number: _____

Department/Division: _____

Enrollment Type: _____

Payroll ID: _____

Class: _____

Annual Earnings: _____

Occupation: _____

Employment Date: _____

Effective Date: _____

Minimum Hours Worked Per Week: _____

If applicable, IMS will not pay claims until other insurance information is provided.

Group Health Coverage Options:

	None	Employee Only	Employee & Child	Employee & Spouse	Employee & Family
Medical Plan (I) (A) (High) (Basic)					
Medical Plan (II) (B) (Low) (Premium)					
Medical Plan (III) (C)					
Indemnity					
Dental Plan					
Vision Plan					
Short Term Disability					
Long Term Disability					
Flex-Unreimbursed Medical					
Flex-Dependent Childcare					

***Life Insurance Coverage Options:**

	Yes	No	Flat Amount / X Salary
Group Life:			
Group Life AD&D:			
Dependent Spouse Life:			
Dependent Spouse Life AD&D:			
Dependent Child(ren) Life:			
Dependent Child(ren) Life AD&D:			
Optional Employee Life:			
Optional Employee Life AD&D:			
**Optional Spouse Life:			
Optional Spouse Life AD&D:			
**Optional Dependent Life:			
Optional Dependent Life AD&D			

*Please note Medical evidence of insurability may be required for any employee who applies for coverage more than 31 days past his/her eligibility date and later requests coverage.

**Please note when electing Optional Spouse Life and Optional Dependent Life the proceeds in event the spouse or dependent dies is automatically paid to the Employee.

Primary Beneficiary Designation: *(For Life Insurance Only)- On the lines below, list the individual(s) who should receive proceeds in the event of your death. You may specify as many individuals as you like, but the total must equal 100%. This is your primary beneficiary. Attach any additional pages if necessary*

	1.	2.	3.
Name:			
Relationship:			
Birth Date:			
SSN:			
Percentage:			

Secondary Beneficiary Designation: *(For Life Insurance Only)-On the lines below, list the individual(s) who should receive proceeds ONLY IF ALL of the individuals listed above are not living at the time of your death. This is your secondary (or contingent) beneficiary. They are not paid if anyone listed above is alive when you die. Attach additional pages if needed.*

	1.	2.	3.
Name:			
Relationship:			
Birthdate:			
SSN:			
Percentage:			

Spouse's Information	
NAME:	
ADDRESS:	
CITY, STATE, & ZIP CODE	
PHONE:	BIRTH DATE:
SSN:	SEX:

Spouse's Employer
EMPLOYER:
ADDRESS:
CITY, STATE, & ZIP CODE
PHONE:
OTHER INSURANCE COVERAGE: MEDICAL _____ DENTAL _______ VISION _____ INDEMNITY _____

Spouse's Insurance
INSURANCE COMPANY:
ADDRESS:
CITY, STATE, & ZIP CODE
PHONE:
POLICY NUMBER:

***Dependent Information*-** *Complete this section on all dependents you want covered.*

NAME:	*SOCIAL SECURITY NUMBER:*	*RELATIONSHIP TO INSURED:*	*BIRTH DATE:*	*SEX:*

Is this dependent covered by other insurance, including Medicare/Medicaid? __________ *If so we need the following information:*

Name of Insurance Carrier: __________________________ *Policy Number:* _________________ *Phone Number:* ____________________

NAME:	*SOCIAL SECURITY NUMBER:*	*RELATIONSHIP TO INSURED:*	*BIRTH DATE:*	*SEX:*

Is this dependent covered by other insurance, including Medicare/Medicaid? __________ *If so we need the following information:*

Name of Insurance Carrier: __________________________ *Policy Number:* _________________ *Phone Number:* ____________________

NAME:	*SOCIAL SECURITY NUMBER:*	*RELATIONSHIP TO INSURED:*	*BIRTH DATE:*	*SEX:*

Is this dependent covered by other insurance, including Medicare/Medicaid? __________ *If so we need the following information:*

Name of Insurance Carrier: __________________________ *Policy Number:* _________________ *Phone Number:* ____________________

NAME:	*SOCIAL SECURITY NUMBER:*	*RELATIONSHIP TO INSURED:*	*BIRTH DATE:*	*SEX:*

Is this dependent covered by other insurance, including Medicare/Medicaid? __________ *If so we need the following information:*

Name of Insurance Carrier: __________________________ *Policy Number:* _________________ *Phone Number:* ____________________

I AUTHORIZE any physician, dentist, medical practitioner, hospital, pharmacy or other provider of health care, any insurance company, government agency or consumer reporting agency to disclose to Insurance Management Services or my employer all information and records relating to diagnosis, treatment, medical history, physical or mental condition and evaluation, or any other information relating to me, my spouse, or my dependent children. I understand that any information obtained will not be released to any person or organization except re-insurers, other persons or organizations performing business or legal services in conjunction with my coverage, or as required by law, or as I may authorize. A photocopy of this authorization remains valid for the term of coverage. I have the right to receive a copy of this authorization upon request.

Employee Signature ____ *Date* __________________________

REFUSAL OF GROUP HEALTH COVERAGE

This is to certify I have been given an opportunity to apply for group health coverage available to me through my Employer, and I have decided to not apply coverage for:

_______ *Myself* _______ *Spouse* _______ *Child(ren)*

REASON FOR REFUSAL

______ *Other Coverage* ______ *Other Reason* ____

Employee Signature ____ *Date* __________________________

SPECIAL ENROLLMENT RULES

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependent in this Plan, provided that you request enrollment within 30 days after your coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption