□ New Applicant □ Coverage Change
□ COBRA Applicant □ Information Update
□ Waiver (See Section 5) Acct Admin:

This is not an application for insurance

GROUP BENEFIT SERVICES, INC.
6 North Park Drive, Suite 310
Hunt Valley, MD 21030

EMPLOYEE ELECTION FORM

1. EMPLOYEE INFORMATION (Your employer will complete the shaded boxes in this section)

Employer Section
GBS Account #: 003-001-2085

Last Name	First Name	M.I.	Social Security Number
			/ /

Effective Date(s):

Street Address			Date of Hire

Annual Salary:
$ _____

City	State	Zip Code	Occupation

Choose your Class:
☐Active Employee
☐Retiree

Sex	Date of Birth	Home Phone Number	Business Phone
□ Male □ Female			
Marital Status □ Single □ Married □ Divorced □ Widowed	Date of Marriage/Divorce	Hours Worked Per Week	**American Society for Engineering Education - Post Doctoral**

Choose your Division:
☐NRL
☐NRL 25
☐NSWC IH

2. INFORMATION FOR SPOUSE and/or CHILDREN TO BE COVERED ON THE PLAN (Complete entire line for all listed)

	Last Name First Name	Social Security #	Gender	Date of Birth	Disabled (Yes/No)	If in HMO plan, identify your PCP Provider ID
Self		/ /				
Spouse		/ /				
Child		/ /				
Child		/ /				
Child		/ /				
Child		/ /				

3. OTHER HEALTH INSURANCE INFORMATION (You must complete this section or claims may be denied)

Do you or your dependents listed on this form have "health" coverage with another insurer? □ Yes □ No Effective Date: _____ Term. Date: _____
Who is covered? □ Self □ Spouse □ All Other Carrier Name: _____ Policy # _____
Will you or your dependents continue coverage with other insurer? □ Yes □ No Other coverage is through □ Individual Policy □ Spouse's Employer
Are you covered by **Medicare**: □ No □ Yes Effective Date (Part A) _____/_____/_____ (Part B) _____/_____/_____ Medicare # _____
Are any of your dependents covered by **Medicare**: □ No □ Yes Effective Date (Part A) ____/____/____ (Part B) ____/____/_____ Medicare # _____

4. BENEFIT ELECTION (Indicate which plan you elect/waive as well as coverage type)

Medical	Dental	Vision	Life/AD&D	Voluntary Life/AD&D
CIGNA	CIGNA	VSP	SUNLIFE	SUNLIFE
Plan: [ ] Open Access Plus Plan: [ ] Open Access Plus with abortions Plan: [ ] Open Access Plus without abortions	Plan: [ ] Dental PPO	Plan: [ ] Vision	[X] ER PAID LIFE/ADD [X] ER PAID LTD	[ ] EE VOLUNTARY LIFE AMNT $_____ [ ] WAIVE
Coverage Type: [ ] Employee Only [ ] Employee & Spouse [ ] Employee & Child(ren) [ ] Family [ ] WAIVE (complete Waiver Section 5)	**Coverage Type:** [ ] Employee Only [ ] Employee & Spouse [ ] Employee & Child(ren) [ ] Family [ ] WAIVE	**Coverage Type:** [ ] Employee Only [ ] Employee & Spouse [ ] Employee & Child(ren) [ ] Family [ ] WAIVE		[ ] SP VOLUNTARY LIFE AMNT $_____ [ ] WAIVE [ ] DEP VOLUNTARY LIFE AMNT $_____ [ ] WAIVE

Life Insurance Primary Beneficiary:	**Percentage:**	**Relationship:**
Life Insurance Secondary Beneficiary:	**Percentage:**	**Relationship:**

Important - Special Carrier Information/Waiver Information Below - Please Read and Check All That Apply

❑ **GBS Advantage HRA**

I understand that my elections are binding for the entire Plan Year and cannot be revoked, modified or amended unless due to a limited family status change. Under penalty of perjury I agree to use the debit card solely for the purchase of eligible expenses not covered by any other plan. I am responsible for providing proof to support reimbursed expenses and agree that any reimbursed expenses later discovered to be ineligible may be deducted from my paycheck by my employer. I authorize the release of claims information to my employer and Group Benefit Services, Inc.

5. WAIVER

I hereby certify that the benefits provided by my employer have been explained to me, that I have been given opportunity to elect coverage and that I voluntarily decline to participate in the benefits checked "Waive" at this time. I understand that I may be required to wait until the next open enrollment period for medical or dental coverage, or be required to provide evidence of insurability for life or disability benefits.

EMPLOYEE SIGNATURE (Waiver Only): _____ **Date:** _____

Reason for Waiver: ☐ **Coverage Elsewhere** **Carrier Name:** _____ ☐ **Not Interested**

CERTIFICATION: I hereby apply on behalf of myself and each dependent listed above, for the coverage(s) indicated. If this form is accepted, coverage will be provided according to the terms and conditions of the contract between the carrier(s) and my employer. I agree to pay current and future changes for coverage provided in excess of the employer contribution. Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. I have carefully read this form and agree to its terms. The recorded answers on this form are, to the best of my knowledge and belief, full, complete and true as of this date. I certify that I am the spouse, parent or legal guardian (or the dependent has been placed in my home for adoption) of the dependents listed above, they are dependent upon me for primary support as defined by the IRS. If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a membership services representative before signing this election form.

EMPLOYEE SIGNATURE: _____ **DATE:** _____

EMPLOYER SIGNATURE: **DATE:**