

## Employee Enrollment Form

## FORM B

**EMPLOYER MUST FAX COMPLETED FORM to SRM (HOPE Trust Plan Administrator) at 309-543-6607**

### REASON FOR ENROLLMENT

(to be completed by Employer; check all boxes that apply)

New Enrollment: \_\_\_\_\_ New Hire/Full-Time (Date: \_\_\_\_\_) \_\_\_\_\_ Open Enrollment  
 Special Enrollment: \_\_\_\_\_ Dependent Spouse Addition \_\_\_\_\_ Dependent Child Addition  
 \_\_\_\_\_ Involuntary Loss of Coverage \_\_\_\_\_ Birth \_\_\_\_\_ Adoption  
 \_\_\_\_\_ Marriage \_\_\_\_\_ Other: \_\_\_\_\_  
 Date of Event Triggering Special Enrollment (mm/dd/yy): \_\_\_\_\_

### EMPLOYEE INFORMATION

\_\_\_\_\_ Date of Hire (Full-Time) (mm/dd/yy) \_\_\_\_\_ Social Security Number  
 \_\_\_\_\_  
 Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Date of Birth (mm/dd/yy) \_\_\_\_\_  
 \_\_\_\_\_ Male \_\_\_\_\_ Female  
 Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ Gender (circle one)  
 \_\_\_\_\_ Single \_\_\_\_\_ Widowed or Divorced \_\_\_\_\_ Married or Civil Union  
 \_\_\_\_\_ Home (or Cell) Phone Number \_\_\_\_\_ Marital Status (circle one)  
 \_\_\_\_\_ E-mail Address \_\_\_\_\_

### DEPENDENTS TO BE COVERED

First Name	M.I.	Last Name (If Different)	Soc. Sec. #	Relationship (Spouse/Son/Daughter)	Date of Birth (mm/dd/yy)
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

### PLAN OPTION SELECTION

Traditional Major Medical Plan →  Self  Spouse  Child(ren)  
 QHDHP (HSA-Compatible) →  Self  Spouse  Child(ren)  
 Health Reimbursement Plan (HRP) →  Self  Spouse  Child(ren)

**Dental & Vision Plan (Optional)**

Self  Spouse  Child(ren)

Other; if Other, please explain:

**NOTE:** A covered employee and his/her covered dependents MUST generally be covered under the same plan option, with the exception of dependent election or declination of Dental & Vision coverage.

**Continued on next page -->**

**Employee Enrollment Form (continued)**

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**INFORMATION ABOUT OTHER COVERAGE**

Will you or any of your covered dependents (spouse and/or child(ren)) keep other coverage in addition to this coverage? **YES** **NO**

Are you or any of your covered dependents (spouse and/or child(ren)) covered through a **spouse's employer plan**? **YES** **NO**

		Self	Spouse	Child(ren)
Spouse's Employer	Insurance Company	Who is Covered on Spouse's Plan? (circle all that apply)		

Are you or any of your covered dependents (spouse and/or child(ren)) covered through **Medicare**? **YES** **NO**

If Yes, Who?  Self  Spouse  Child(ren)      If Yes, Why?  Age  Disability  Kidney Failure

Type of Coverage:  Part A  Part B  Part D

Are any of your covered dependents (spouse and/or child(ren)) totally or temporarily disabled? **YES** **NO**

If Yes, Who? \_\_\_\_\_ Date of Disability: \_\_\_\_\_

Are you or any of your covered dependents (spouse and/or child(ren)) covered through **Medicaid**? **YES** **NO**

If Yes, Who?  Self  Spouse  Child(ren)

Are you or any of your covered dependents (spouse and/or child(ren)) covered through **Tri-Care**? **YES** **NO**

If Yes, Who?  Self  Spouse  Child(ren)

**MEDICAL HISTORY**

Have you or any of your covered dependents (spouse and/or child(ren)) been diagnosed with or have planned future surgeries or treatments for heart disease, cancer, neck or back disorder, kidney/renal disease or failure, organ or tissue transplant, or AIDS/HIV/autoimmune disease?

**YES**      **NO**      If Yes, indicate Who, and please provide an additional explanation below (*attach additional pages, if needed*):

**ACKNOWLEDGEMENT & SIGNATURE**

I understand, agree, and represent that I have read this document or it has been read to me; the answers provided within this entire Employee Enrollment Form are, to the best of my knowledge and belief, true and complete; and if I intentionally omit or provide false information on or in relation to this Employee Enrollment Form, then this coverage may be cancelled retroactively, in which case any claim I incur may not be paid by the plan and I may face legal liability. I understand further that the information I have provided in this Employee Enrollment Form will be used by the plan and its affiliates to make decisions about eligibility, enrollment, and underwriting. Finally, I authorize any physician, nurse, hospital, dentist, other person, or firm to obtain from the plan information and copies or records pertaining to medical and prescription expenses incurred by me or my family members enrolled in the plan. A photographic copy of this Employee Enrollment Form and Acknowledgement & Signature shall be as valid as the original.

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date