Dearborn Group™

Enrollment and Change Form

Administrative Office: 701 E. 22nd Street, Lombard, Illinois 60148

NOTICE TO CONSUMER: This is a limited benefits health plan. The benefits provided are supplemental to, and not a substitute for, major medical coverage, even in combination with other limited benefits plans. To apply for an individual or small-group major medical plan, please visit the website of the New Mexico Health Insurance Exchange at www.bewellnm.com or call 1-833-862-3935 (TTY: 711).

❑ New Enrollment ❑ Change ❑ Open Enrollment ❑ COBRA ❑ Retiree

Employer/Employee Section

Enrollment forms must be submitted directly to us unless the group is self-administered. If the group is self-administered, submit enrollment forms to us only if evidence of insurability is required.

EMPLOYER	GROUP NO. / ACCOUNT NUMBER	LOCATION

EMPLOYEE NAME - LAST	FIRST	MIDDLE INITIAL	SEX M ❑ F ❑	DATE OF BIRTH	DATE OF HIRE [(FULL TIME)]

SOCIAL SECURITY NO.	EARNINGS $ Weekly ❑ Monthly ❑ Annual ❑	JOB TITLE	CLASS

HOME ADDRESS	CITY	STATE	ZIP

HOME PHONE	WORK PHONE	CELL PHONE

Spouse Name - Last (If Applicant)	First	M.I.	Sex ❑ M ❑ F	Spouse Date of Birth	Spouse Social Security #

Has the Employee (if applying) used **any** tobacco products in the last 2 years?	❑ Yes ❑ No
Has the Spouse (if applying) used **any** tobacco products in the last 2 years?	❑ Yes ❑ No

BENEFIT SELECTION - Life, Disability, Critical Illness, Accident, Hospital Indemnity & AD&D

COVERAGE SELECTION: Your non-medical group insurance program may not include all the benefits listed below. **Ask your Employer for the details about the benefits available to you, your cost, if any, and whether you will be required to complete a health questionnaire.**

Basic Coverage (Check all that apply) Spouse includes Domestic Partner and Party to a Civil Union as defined in the Certificate.		
☐ Term Life / AD&D	☐ Short-Term Disability (STD)	☐ Long-Term Disability (LTD)
☐ Dependent Term Life / AD&D	☐ Critical Illness ☐ Spouse ☐ Child(ren)	☐ Accidental Death and Dismemberment (AD&D)
☐ Accident ☐ Spouse ☐ Child(ren) ☐ Family	☐ Hospital Indemnity ☐ Spouse ☐ Child(ren) ☐ Family	

Supplemental Coverage (Check all that apply) Spouse includes Domestic Partner and Party to a Civil Union as defined in the Certificate.		(A)Add, (C)Change (D)Delete	Total Amount of Coverage Desired	If (C)hange, list Prior Coverage
☐ Term Life / AD&D	Employee			
☐ Term Life / AD&D	Spouse			
☐ Term Life / AD&D	Child(ren)			
☐ Critical Illness	Employee			
☐ Critical Illness	Spouse			
☐ Critical Illness	Child(ren)			
☐ AD&D	Employee			
☐ AD&D	Spouse			
☐ AD&D	Child(ren)			

Voluntary Coverage (Check all that apply) Spouse includes Domestic Partner and Party to a Civil Union as defined in the Certificate.		(A)Add, (C)Change (D)Delete	Total Amount of Coverage Desired	If (C)hange, list Prior Coverage
☐ Term Life	Employee			
☐ Term Life	Spouse			
☐ Term Life	Child(ren)			
☐ AD&D	Employee			
☐ AD&D	Spouse			
☐ AD&D	Child(ren)			
☐ AD&D	Dependents			
☐ AD&D	☐ Employee ☐ Family			
☐ Long-Term Disability (LTD): Incremental				
☐ Long-Term Disability (LTD): % of Earnings				
☐ Short-Term Disability (STD): Incremental				
☐ Short-Term Disability (STD): % of Earnings				
☐ Critical Illness	Employee			
☐ Critical Illness	Spouse			
☐ Critical Illness	Child(ren)			
☐ Accident	Employee			
☐ Accident	Employee + Spouse			
☐ Accident	Employee + Child(ren)			
☐ Accident	Family			
☐ Hospital Indemnity	Employee			
☐ Hospital Indemnity	Employee + Spouse			
☐ Hospital Indemnity	Employee + Child(ren)			
☐ Hospital Indemnity	Family			

BENEFICIARY DESIGNATION: (For Employee Only: Must Be Completed if you have applied for Life or AD&D insurance.) If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages, the total must equal 100%. (Employee is the beneficiary of proceeds from spouse or child coverage.)

First Name Last Name	Social Security No.	Date of Birth	Relationship	Percentage
Primary				%
Primary				%
Contingent				%
Contingent				%

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BENEFIT SELECTION ☐ VISION

ENROLLMENT
Spouse includes Domestic Partner and Part to a Civil Union as defined in the Certificate.
(Choose One)
- ☐ Employee
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Family

POLICY CHANGE
(Check Reason for Change)
- ☐ Married
- ☐ Birth / Adoption
- ☐ Widowed
- ☐ Divorced
- ☐ Address Change

CANCEL COVERAGE
- ☐ Terminate Coverage
  Date _____
- ☐ Leave / Layoff
- ☐ Other
  Date _____

COBRA CONTINUATION PRIVILEGE

Start Date: _____

Projected End Date: _____

Previously covered with group as:
- ☐ 1. Employee (termination, reduction in hours, other)
- ☐ 2. Spouse (divorce from Employee, death of Employee)
- ☐ 3. Dependent (reached age limit, married, no longer a Full Time Student, other)
- ☐ 4. Spouse & Dependents (divorce from Employee, death of Employee, other)

For the purposes of this Notice, while prohibited by Federal law, Spouse does not include a same-sex Domestic Partner or Party to a Civil Union. Such benefits may be available under state law of provided by the policyholder.

COVERED SPOUSE AND DEPENDENTS

Dependent Child(ren) over the age limit, indicate if Full Time Student (FTS) or Handicapped (HDCP).

First Name	Last Name	Social Security Number	Date of Birth	Relationship	SEX	Adult Child FTS or HDCP	Name of Accredited School
				SPOUSE	☐ M ☐ F		
					☐ M ☐ F		
					☐ M ☐ F		
					☐ M ☐ F		
					☐ M ☐ F		
					☐ M ☐ F		

I hereby request to be insured and authorize deductions, if any, from my compensation for my share of the cost of the benefits to which I may be entitled under the group policy (ies) issued to the Employer listed above. I understand that if I am not actively at work on the effective date of my coverage, my insurance will not begin until the day I return to work. I understand that if I do not remain actively at work that my coverage may lapse or terminate. For those coverages I have declined, I understand that if I choose to enroll at a later date, my cost may be higher and a health questionnaire may be required.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss, or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and penalties.

We do not discriminate in eligibility for coverage or benefits on the basis of sex, sexual orientation, gender, gender identity, race, religion, or national origin.

Notice: The sale of Critical Illness is prohibited to individuals covered by any Title XIX program (Medicaid, Centennial Care or any similar name).

I understand I am not purchasing major medical insurance.

Long Term Disability, Short-Term Disability, Critical Illness and Hospital Indemnity]insurance are subject to a pre-existing conditions exclusion.

FOR OFFICE USE ONLY

EMPLOYEE SIGNATURE _____ DATE _____

Waiver of Coverage:
I DO NOT WISH TO ENROLL at this time and understand that the opportunity to enroll at any future time will be subject to such arrangements as may be made with the company.

EMPLOYEE SIGNATURE _____ DATE _____