ENROLLMENT AND WAIVER FORM

☐ New Enrollment
☐ Enrollment change effective on ____________
☐ Open Enrollment
☐ Special Enrollment
☐ Late Enrollment

14 COMMERCE ROAD
P.O. BOX 5508
NEWTOWN, CONNECTICUT 06470-5508

WE ARE YOUR THIRD PARTY ADMINISTRATOR
Phone: 800-678-8161

EMPLOYER

Shaded Areas for T R PAUL Use Only

(Please Print)

Name of Employee ____________
Last Name | First Name | MI

Address ____________
Number | Street | Apt. #

City | State | Zip Code

FEMALE ☐ MALE ☐	IDENTIFICATION NUMBER	DATE OF BIRTH Month / Day / Year	ANNUAL SALARY	SOCIAL SECURITY NUMBER	SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐
				___ / ___ / _____	

Note: You *must take* all coverages offered by your employer for which your employer pays the full cost. You *may elect* any or all coverages offered by your employer for which you pay a portion of the cost.

I AM ENROLLING IN:	YES	NO**	VOLUME	BENEFIT CLASS
Group Life and AD & D				
Supplemental Life				
Dependent Life				
Weekly Income (STD)				
Long Term Disability				

I AM ENROLLING IN:	EMPLOYEE	DEPENDENT	NO
Medical			
Prescription			
Dental			
Vision			

LOCATION	EFFECTIVE DATE OF COVERAGE			JOB TITLE	HOURS WORKED PER WEEK FOR THIS EMPLOYER	DATE OF FULL TIME EMPLOYMENT		
	Month	Day	Year			Month	Day	Year

MY BENEFICIARY IS: ____________ RELATIONSHIP ____________
First Name | MI | Last Name

CONTINGENT BENEFICIARY (IES): If more than one named, the beneficiaries shall share equally unless otherwise stated below.

DO YOU HAVE PRIOR CREDITABLE COVERAGE?

☐ YES ☐ NO

IF YES, ATTACH PROOF

LIST BELOW ALL ELIGIBLE DEPENDENTS INCLUDING SPOUSE

Name of Dependent	Date of Birth	Social Security Number	Relationship
			Spouse

SPOUSE'S EMPLOYMENT INFORMATION

Name:

Name and Address of Employer:

Medical Insurance? ☐ YES ☐ NO

Carrier:

Dental Insurance? ☐ YES ☐ NO

Carrier:

****WAIVER OF BENEFITS** ☐ (Check here if waiving any coverage other than medical or dental.)

I have been given the opportunity to participate in all of the coverages for which I am eligible which are offered by my company's Group Benefit Plan and have declined certain coverages as indicated above. If at a later date I wish to apply for previously waived coverages (other than medical coverage), I understand that before I can be covered, I may, at my own expense, be required to furnish evidence of insurability which is satisfactory to the Insurance Company and my Employer.

I hereby authorize the Employer to make any required deduction from my wage or salary for the cost of the benefits in which I have enrolled.

I authorize any physician, medical practitioner, hospital, clinic or other medically related facility, insurance or reinsurance company, or employer having information available as a diagnosis, treatment or prognosis with respect to any physical or mental condition and/or treatment of me or my dependents and any other non-medical information of me or my dependents to give to the group policyholder, my employer, T R Paul, Inc. or its legal representative any and all such information.

I understand the information obtained by use of the Authorization will be used by T R Paul, Inc. to determine eligibility for insurance and benefits under an existing policy. Any information obtained will not be released by TR Paul, Inc. to any person or organization EXCEPT to the group policyholder, my employer, reinsuring companies or other persons or organizations performing business or legal services in connection with a claim, or as may be lawfully required or as I may further authorize.

____________ EMPLOYEE SIGNATURE ____________ DATE OF SIGNATURE

____________ REVIEWED BY COMPANY ADMINISTRATOR ____________ DATE

REMARKS:

EMPLOYER:
RETURN BOTH COPIES TO T R PAUL INC.

EMPLOYER COPY

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