ENROLLMENT / CHANGE CARD

P.O. Box 6927, Columbia, SC 29260
(803) 462-0151 / (800) 768-4375 FAX: (803) 462-6850

NOTE: Please refer to the back of this document for important information regarding Pre-Existing Condition Exclusions.

ENROLLMENT REASON
☐ NEW ENROLLMENT
☐ CHANGE

(Check as applicable) PAYROLL DEDUCTION: ☐ EMPLOYEE ☐ DEPENDENT (For PAI use only) NO LOSS NO GAIN: EE ☐ DEP☐ NONE ☐

Employee Information

EMPLOYER: | GROUP #: | LOCATION #
EMPLOYEE NAME: | SOCIAL SECURITY #:
ADDRESS: | CITY: | STATE: | ZIP CODE:
DATE OF BIRTH: | SEX: M ☐ F ☐ | MARITAL STATUS: SINGLE ☐ MARRIED ☐ DIVORCED ☐
DATE EMPLOYED: | COVERAGE EFFECTIVE DATE: | WAITING PERIOD (days): 30 ☐ 60 ☐ 90 ☐

Healthcare Coverage

COVERAGE SELECTION	***Medical***	***Dental***	***Vision***
SINGLE	☐	☐	☐
EMPLOYEE & SPOUSE	☐	☐	☐
EMPLOYEE & ☐1 ☐2 ☐3+ children	☐	☐	☐
FAMILY	☐	☐	☐

Dependent Coverage

PLEASE LIST ANY DEPENDENTS (AGE 19 AND OVER) WHO ARE ELIGIBLE FOR THEIR OWN EMPLOYER SPONSORED MEDICAL HEALTH INSURANCE.

NAME____RELATIONSHIP___________________________

NAME____RELATIONSHIP___________________________

NAME____RELATIONSHIP___________________________

Dependent Information

Relationship	Legal Name: Last Name	First Name	M.I.	Social Security #	Date of Birth	Gender M / F
☐ SPOUSE ☐ DOMESTIC PARTNER						
CHILD						
CHILD						
CHILD						
CHILD						

IF CHANGING COVERAGE, PLEASE LIST BELOW: EFFECTIVE DATE OF CHANGE_____________________________

☐ NAME CHANGE FROM____ TO ____

☐ BENEFICIARY CHANGE TO: NAME____RELATIONSHIP______________________

☐ SINGLE TO FAMILY (LIST ADDED DEPENDENTS ABOVE.)

☐ FAMILY TO SINGLE (LIST DELETED DEPENDENTS ABOVE.)

☐ ADD DEPENDENT(S) (LIST ABOVE.)

☐ DELETE DEPENDENT(S) (LIST ABOVE.)

☐ CHANGE LIFE VOLUME FROM___________________________ TO __________________________DATE________________

Other Coverage

Do you or does any member of your family have other group health, dental or drug coverage, Federal Employees' Program (FEP) or Medicare?

☐ Yes ☐ No If YES: ☐ MEDICARE Effective Date______________ Health Insurance Claim Number (HICN)___________________

A. Family Member's Name____and Social Security #_____________________

B. Name of Insurance Co.____ Policy #_______________ Effective Date_____________

C. Family Member's Employer____

D. List Names of Covered Person(s) 1___________________ 2__________________ 3_________________ 4_________________

E. Please check each type of service covered by the policy: ☐ Hospital ☐ Physician / Medical ☐ Prescription Drugs ☐ Dental ☐Vision

I HEREBY CERTIFY THAT I AM AN ACTIVE FULL-TIME EMPLOYEE. IT IS FURTHER UNDERSTOOD THAT THE ACCEPTANCE OF MY PREMIUM BY MY EMPLOYER AT ANY TIME SHALL NOT OPERATE AS A WAIVER OR ESTOPPEL WITH RESPECT TO ANY PROVISION OF THE GROUP CONTRACT, INCLUDING THE PROVISIONS CONCERNING ME OR MY DEPENDENTS' ELIGIBILITY. I HEREBY CERTIFY THAT THE FOREGOING STATEMENTS, INCLUDING ANY ACCOMPANYING STATEMENTS, ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I HEREBY AUTHORIZE ANY HEALTH PROVIDER OR MY EMPLOYER TO RELEASE ANY RECORDS OR INFORMATION TO PLANNED ADMINISTRATORS, INC. ON MYSELF OR DEPENDENTS. A COPY OF THIS RELEASE IS AS VALID AS THE ORIGINAL. I HEREBY AUTHORIZE MY EMPLOYER TO DEDUCT THE REQUIRED PREMIUM CONTRIBUTIONS, IF ANY, FROM MY PAYROLL EARNINGS.

Employee Signature____ Date____________________________

SIGN BELOW IF YOU DO NOT ELECT TO BE COVERED

I HEREBY CERTIFY THAT I HAVE BEEN OFFERED AN OPPORTUNITY TO BECOME COVERED UNDER THE PLAN SPONSORED BY MY EMPLOYER AND I HAVE DECIDED NOT TO TAKE ADVANTAGE OF THIS OFFER.

Employee Signature____ Date____________________________

Revised September 2010

PRE-EXISTING CONDITIONS EXCLUSIONARY PERIOD

This plan imposes a pre-existing condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy or to a child who is enrolled in the plan within 30 days after birth, adoption or placement for adoption.

Please note that, due to 2010 Health Care Reform legislation, effective upon renewal of your employer's plan on or after 09/23/10, dependents under the age of 19 will no longer be subject to a Pre-Existing Condition Exclusionary Period.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the pre-existing condition exclusion and creditable coverage should be directed to Eligibility Department, Planned Administrators, Incorporated, P.O. Box 6927, Columbia, South Carolina 29260, or call us at: (800) 768-4375 or (803) 462-0151.