AZ MT ARIZONA Metropolitan Trust

GROUP HEALTH BENEFIT ENROLLMENT AND CHANGE FORM

AmeriBen
P.O. Box 7186 Boise, ID 83707

GROUP #_____ DIVISION_____

LOCATION_____

Do Not Write in this Area ~ For AmeriBen/IEC Group Use Only
Dep_____ Rx_____ ID_____ Misc_____ Eff. Date_____/_____

Employee Information

Employee Last Name	First Name	Middle Initial

Mailing Address	Social Security #

City	State	ZIP

Gender ☐ F ☐ M	Date of Birth (Month Day Year)	Daytime Phone Number	Marital Status ☐ S ☐ M ☐ W ☐ D

Date of Full Time Employment (Month Day Year)	Date Eligible for Benefits (Month Day Year)

Reason Codes & Dependent Information (Employee Enrollment Required)

Reason for Enrollment: ☐ New Hire ☐ Open Enrollment Period ☐ Marriage ☐ Birth/Adoption ☐ Divorce ☐ Other_____
☐ Loss of other Group Health Coverage (proof required)

Employee Coverage Desired ☐ Medical/RX ☐ Dental ☐ Vision ****Employee Coverage and any Dependents coverage must ALL be the same**
☐ Employee Only ☐ Employee +Spouse ☐ Employee + Child(ren) ☐ Employee + Family

Reason for Disenrollment: ☐ Divorce ☐ Dependent Child reached limiting age ☐ Death ☐ Termination ☐ Other_____

Date of Marriage, Birth/Adoption, Loss of Other Coverage, Divorce, Death or Child Reached Limiting Age:_____

Have you or your dependents had insurance within the last 62 days? ☐ ***Yes (Please provide creditable coverage letter)*** ☐ ***No***

ENROLLMENT OR DISENROLLMENT: Complete this section for **each** person who wants to enroll (add) or drop coverage

		First and Last Name	MI	Gender	DOB	SS#	Child lives with employee?	Indicate A = Add D = Drop	Type of Coverage: Medical	Dental	Vision
1	Employee										
2	Spouse										
3	Child										
4	Child										
5	Child										
6	Child										

Other Coverage Information

1. Does the policyholder have any other insurance in addition to the policy with Arizona Metro Trust?
☐ Yes ☐ No If yes ☐ Medical ☐ Dental

2. Do any dependents (spouse/children) have other insurance in addition to the policy with Arizona Metro Trust?
☐ Yes ☐ No If yes ☐ Medical ☐ Dental

Do you or your dependents have Medicare coverage? ☐ Yes ☐ Part A ☐ Part B ☐ ESRD ☐ No

If this section is not completed, the processing of your claims may be delayed.

(If NO to both questions above please disregard the rest of this section and sign & date the bottom of this form)

	Medical	Dental
Name & Date of Birth for Policy Holder		
Other Insurance Name & Phone Number		
Other Insurance Address		
Policy Number or SS#		
Effective Date of Policy		
Name & Birth date of all other dependents covered under this policy		

If your dependent children are covered under another policy and the natural parents are divorced or separated, insurance regulations require the following information:

a. Do parents have joint custody? ☐ Yes ☐ No
If No, please provide the name of the parent with primary custody_____

b. If divorced, is any court order in place mandating which policy pays first? ☐ Yes ☐ No
If Yes, please submit a copy of the divorce decree

The group benefits available through the group policy of my employer have been explained to me and I understand the scope of the benefits. I hereby apply for benefits to which I am entitled or to which I may become entitled under the terms of the group policy or policies issued to the policyholder. I authorize the deduction from my earnings of any contribution I am required to make toward the cost of this benefit. I acknowledge by signing this form that all the information provided is true and correct to the best of my knowledge. Misrepresentation of information can result in cause for termination, loss of coverage and criminal and/or civil prosecution. I understand that if I do not enroll myself or my dependents, I must read and sign the waive portion of this form.

Signature_____ Date_____

Dependent Child(ren) status if over 19

Name		Date of Birth	Social Security Number
☐	Full Time Student _____ # of credit hours	Name/Address of School	
☐	Married	Date of Marriage	
☐	In Military	Date of Enlistment	
☐	Employed Full Time	Date of Employment	
Name		Date of Birth	Social Security Number
☐	Full Time Student _____ # of credit hours	Name/Address of School	
☐	Married	Date of Marriage	
☐	In Military	Date of Enlistment	
☐	Employed Full Time	Date of Employment	

Life Insurance Beneficiary Designation

Beneficiary Designation (Full Name)	Relationship	SS#	
Mailing Address	City	State	ZIP
Contingent Beneficiary Designation (Full Name)	Relationship	SS#	
Mailing Address	City	State	ZIP

Waiver of Coverage

COMPLETE AND SIGN THIS SECTION ONLY IF WAIVING COVERAGE*

☐ **Medical/Rx, Dental, Vision** benefits are being waived for -Name of Person(s)_____
for the following reason(s) _____

☐ **Medical/Rx, Dental, Vision** benefits are being waived for -Name of Person(s)_____
for the following reason(s) _____

☐ **Medical/Rx, Dental, Vision** benefits are being waived for -Name of Person(s)_____
for the following reason(s) _____

Name of Spouse's Group Plan/Employer _____

Other Coverage_____

- **Group benefits available through the group policy of my employer have been explained to me and I understand the scope of the benefits.**
- **I waive coverage for myself and/or my dependents and elect not to participate.**
- **I understand that I am waiving this coverage even though my employer may be providing the coverage at little or no cost to me.**
- **I understand that by waiving enrollment because of other health insurance coverage, I may in the future be able to enroll in this plan, provided that I request enrollment within 30 days after other coverage ends. Please provide the other coverage when you or your dependents are enrolled elsewhere. In addition, I understand if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself or my dependents provided that I request enrollment within 30 days of the status change.**
- **If you waive coverage and have no other coverage, or if you do not indicate that your reason for waiving is because you have other coverage, and then later enroll with us, you are a late enrollee and are subject to an 18 month pre-existing period.**
- **I acknowledge by signing this form that all the information provided is true and correct to the best of my knowledge.**

****Signature of Employee**_____**Date**_____

*****COMPLETE AND SIGN ONLY IF WAIVING COVERAGE****