# EMPLOYEE

# Apex Management Group MEC Enrollment Application

Apex Management Group

## Enrollee Information (All information must be completed to ensure coverage)

| | | | |
|---|---|---|---|
| Last Name | First Name | MI | |
| Date of Birth | Social Security # | Gender | Marital Status |
| Date of Hire | ❑ Part Time ❑ Full Time | Height | Weight |
| Address Line 1 | Address Line 2 | | |
| City | State | ZIP | Employer |
| Phone | Email | | |

## Coverage & Change Request Information (You may be required to provide proof of the event)

Insurance Requested: ❑ New Enrollment ❑ Status Change

Coverage level: ❑ Employee Only ❑ Employee & Spouse ❑ Employee & Child(ren) ❑ Employee & Family

Plan name: ❑ MEC ❑ MEC Plus ❑ MEC Plus Advantage ❑ MEC Plus Advantage with Beazley **GLI**

If changing plans, indicate Qualifying Event: ❑ Marriage ❑ Divorce ❑ Adoption ❑ Returning to School Full-Time
❑ Court Order ❑ Other (specify): _____ Date of Qualifying Event _____

Are you currently actively at work and able to perform the duties of your occupation? ❑ Yes ❑ No

How many hours are you regularly working per week with your current employer? _____ Hours per week

## Family Information (Only for those applying for coverage)

| First Name & MI (Last if different than employee) | Social Security # | Gender | Height | Weight | Date of Birth |
|---|---|---|---|---|---|
| Spouse | | | | | |
| Child | | | | | |
| Child | | | | | |
| Child | | | | | |

## Employee Agreement (Signature required)

I authorize my employer to deduct the necessary contributions toward the benefits I have selected on a pre-tax basis from my pay. I understand that I cannot change the benefits I have selected or revoke this pay deduction authorization before the beginning of the next plan year unless that change or revocation is made on account of, and corresponds with, a change in status, a special enrollment event, or any other event that permits a mid-year change or revocation of elections under the terms of my employer's Section 125 cafeteria plan.

| | |
|---|---|
| Employee Signature | Date |

If signed by a representative of enrollee, please indicate the representative's authority to act on behalf of enrollee:

## Waiver (Only complete this section if you are waiving all coverage)

I am declining coverage for (check all that apply): ❑Employee ❑Spouse ❑Child(ren)

I am declining coverage for the following reason(s): (Check all that apply and note that if you are declining coverage because you have other coverage, you must indicate that on this form. Failure to do so may result in you not being able to exercise special enrollment rights if you lose other coverage).

❑Covered by a spouse's or parent's group health plan ❑Individual medical plan ❑**Not Affordable**

❑COBRA/State Continuation ❑Government Plan (please specify plan name): _____

❑Other reason: _____

**I understand that this waiver may be reported to IRS informing them I have declined the Employer-provided healthcare plan and this may result in fines and repayment of any federal subsidies when selecting insurance through a Health Care Exchange.**

Authorization: As an employee, I hereby apply for, or waive (if indicted), group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary.

| | |
|---|---|
| Employee Signature | Date |