Lotus Technical

Enrollment Form **Group #215114**

Employer Use Only				
Date of Hire	Effective Date	Payroll Effective Date	Location/Department	Annual Salary

EMPLOYEE INFORMATION

Last Name	First Name	Middle Initial

Home Address	City	State	Zip Code

Home Telephone Number ( )	Cell Number ( )	Date of Birth	☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated

Social Security Number	Primary E-mail Address	Secondary E-mail Address:

MEDICAL PLAN

Please choose one below:	Please choose one below:	If waiving, MUST choose one below:
☐ Minimum Essential Coverage (MEC) Plan	☐ Employee	☐ Spouse Group Plan
☐ Minimum Value Plan (MVP)	☐ Employee + Spouse	☐ Individual Plan Purchased on Exchange
☐ I waive coverage, I DO NOT have other coverage	☐ Employee + Child(ren)	☐ Medicare/Medicaid
☐ I waive coverage, I HAVE other coverage	☐ Family	☐ Tricare

DEPENDENT INFORMATION

Complete the following information for each dependent (including spouse) to be covered.

Name: Last, First, MI	Date of Birth M	D	Y	Relationship	Gender (M / F)	Social Security Number *(Required)*
				Spouse		

(List additional children on a separate sheet of paper. Also provide address for children if different from employee's mailing address.)

AUTHORIZATION AGREEMENT

- I understand that in order to be eligible for the coverages I have elected, I must meet any applicable actively at work requirement as defined by the insurance contracts.
- I authorize any physician, medical practitioner, hospital, clinic, or medical related facility, insurance or reinsurance company, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children and any other non-medical information of me or my minor children to give to our Insurance Companies or their legal representative, any and all such information. I authorize the use and disclosure of my Social Security Number in the administration and provision of such benefits as may apply to me or my minor children.
- I understand Special Enrollment Rules may apply if I waive coverage for myself or my dependents when initially eligible, due to other health insurance coverage. If I do not qualify under the Special Enrollment Rules, enrollment will be restricted to once a year during the annual open enrollment period, subject to the pre-existing conditions limitations.
- I understand that providing false information or omission of relevant information on this form may result in the denial of claim(s) and/or termination of coverage.
- By providing my e-mail address, I Authorize and Consent to the use of e-mail for communications regarding my employee benefits. I understand that my e-mail address is private and will be used solely for benefit administration purposes.

Signature_____ Date_____