



GROUP MARKET (51+) ENROLLMENT APPLICATION

P.O. Box 7777, Lancaster, PA 17604-7777
Toll free: 800-796-7460 Fax: 717-581-1319

You, the employee, must complete the application in your own handwriting. Please print clearly using ink. You are solely responsible for its accuracy and completeness. All questions must be answered in full or the application may be returned to you, which may delay the effective date of your coverage.

Employee Information (Must be completed by employee)
Employee Enrollment COBRA Enrollment Plan Selection
Last name First name MI Marital status Gender
Home address Home phone Work phone
City State ZIP Social Security Number
Primary language Email address Date of birth Height Weight Do you smoke?
Employer name Occupation/Job title Hire date Hours worked

Dependent Information (List only those eligible dependents who are enrolling)
Please provide the Social Security Number of dependents and their last name if it is different from your last name. If your dependent child is not legally adopted or is not the birth child of you and/or your spouse, please explain why the child is a dependent. If there is a custodial parent responsible for the care of anyone listed, please attach a copy of a power of attorney or other court-initiated document.

Table with 10 columns: Sex (M/F), Last name, First name, MI, Social Security Number, Height, Weight, Student/Disabled, Birthdate MM/DD/YY, Smoker (Y/N). Rows include Spouse and multiple Dependents.

Other Medical Coverage (All questions must be answered.)

A. Do any persons on this application intend to continue other group coverage if this application is accepted?
B. Does any person applying for coverage have health insurance coverage?
C. Is any person applying for coverage eligible for Medicare?

I understand that my signature and my spouse's signature (if applying for coverage) are mandatory on this release. This application will not be reviewed until these signatures are present. I AGREE: All information on this form is correct and true. I understand that it is the basis on which premiums may be determined under the plan. I further authorize my employer to deduct from my earnings the contribution (if any) required to apply toward the cost of this plan. I certify that I am at the employer's place of business in permanent full-time employment. Even if this application is approved, any misstatements or omissions may result in future claims being denied and the policy being rescinded. I ACKNOWLEDGE THAT I am applying for Preferred Provider Organization (PPO) coverage. I understand I am responsible for a greater portion of the cost of my covered medical costs when I use a non-preferred provider. I understand that under the PPO if I or one of my dependents receives medically necessary covered services from a non-preferred provider, Significa will cover only the lower level benefits set forth in the applicable certificate of coverage, and I will be responsible for payment of any amount not covered.

Conditions of Enrollment - I hereby apply for coverage as checked hereon, made available to me through the group with which I am affiliated. I understand that if this application is accepted, you will provide me with an identification card and certificate of coverage indicating the benefits and conditions of enrollment. I acknowledge that I will be bound by the terms and conditions of the group contract. I am authorized by my dependents listed above to enroll them in a Significa Insurance Group, Inc. health care product. I authorize the Social Security Administration to furnish to Significa Insurance Group, Inc. medical or any other information acquired by it under Title XVIII of the Social Security Act (Medicare) to the extent necessary to process any claim under my agreement. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Signature of employee:
Signature of spouse:
Signature of dependent (over 18):
Signature of dependent (over 18):

My signature as employee is on behalf of myself and all dependents. If a personal representative is authorizing disclosure of the insured's information on behalf of the insured, a copy of a power of attorney or other court-initiated document will be required, if applicable.

To Decline Coverage To be completed only if you, your spouse or your dependent DO NOT want to enroll.

A. Coverage declined for: Myself Spouse Dependent(s) Spouse and dependent(s)
B. Reason for declining coverage (check one): Covered by spouse's group coverage Enrolled in any other insurance carrier plan
Other:
Signature (only if declining coverage for employee and/or dependent(s)) Date (MM/DD/YYYY)

PLEASE COMPLETE THE ENTIRE FORM. THIS FORM WILL NOT BE PROCESSED WITHOUT REQUIRED SIGNATURES.