

Have you or any of your eligible dependents previously been covered by an individual or group health insurance plan? If so, please complete the following. **Please note: A certificate of prior coverage must be provided for all identified prior coverage(s).**

Name of prior carrier: _____

Prior carrier's phone number: _____ I.D. Number: _____

Original effective date: _____ **Paid-to or termination date:** _____

Name of all persons covered under above policy: _____ {Circle One}

If you or any eligible dependents had coverage prior to the above:

Name of prior carrier: _____

Prior carrier's phone number: _____ I.D. Number: _____

Original effective date: _____ **Paid-to or termination date:** _____

Name of all persons covered under above policy: _____ {Circle One}

Are you, your spouse or any of your dependents eligible for benefits under Medicare? Yes [] No []

If Yes, complete the following information:

Name: _____ Hospitalization (Part A) effective date: _____

Relationship: _____ Medical (Part B) effective date: _____

Medicare number: _____

PLEASE READ CAREFULLY: I represent that all answers given are full, complete and true to the best of my knowledge, information and belief. When applicable, I authorize my employer to deduct contributions from my earnings. I understand that: 1) the answers given will be the basis of any coverage provided and this enrollment form will be part of the Plan document; 2) coverage, if approved, may be subject to the pre-existing conditions limitation in the Plan document; 3) any material misstatements or failure to provide sought for information may be used as a basis of rescission of my coverage.

BALTASVISION, LLC: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

AUTHORIZATION TO RELEASE INFORMATION: I give my permission to any Medical or Dental practitioner, hospital, clinic, pharmacy, insurance company, reinsurer, consumer reporting agency, or employer to give my employer and Employee Benefits Administrators. all my information on my behalf or my dependents who are to be covered for the purposes of claims adjudication, benefits determination, and the quoting of insurance in accordance with the plan documents and any laws, legislation or guidelines affecting the same. I know that I have a right to a copy of this authorization. A photocopy will be as valid as the original

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

WAIVER OF COVERAGE

Failure to complete this waiver completely may affect your rights guaranteed under the Health Insurance Portability and Accountability Act of 1996 to future enrollment in the plan should your current coverage ceases.

I am already protected by the contract of my:

Husband

Wife

Parent

None

Through his/her place of employment (give name) _____

whose carrier is: _____

I, the undersigned, an employee of the above named employer hereby certify that I have been given an opportunity to apply for **Medical** and or **Dental** Coverage, as offered by said employer, and after careful consideration, have decided not to take advantage of this offer.

It is my understanding, that in the event I wish to apply for such service hereafter, I may do so, during regular open enrollment periods or exercise Special Enrollment Rights of the group (subject to established procedures).

Employee Signature

Date