Health and Vision Enrollment Form

WEA Insurance Corporation
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Please complete every section and every field on this form. Applications not completed in full cannot be processed.

Section 1–Employee Information

Employee Name (Last, First, Middle Initial)

Gender
☐ Male ☐ Female

Marital Status
☐ Single ☐ Married ☐ Divorced ☐ Widowed

Street Address (or P. O. Box) **City** **State** **Zip**

Date of Birth (MM/DD/YYYY) **Telephone Number** **Email Address**

Social Security Number **Subscriber Number** (not applicable for first time enrollment)

Are you
☐ Totally disabled? ☐ On sick leave? ☐ On medical leave? ☐ Retired? ☐ On COBRA?
If yes, provide start date (MM/DD/YYY): _____

Section 2–Employment Information

Employer Name

WEA Trust Group Number **First Day Worked** (MM/DD/YYYY) **Average Hours Worked/Week**

Occupation

Section 3–Reason for Application

Choose one of the following events:

☐ New employee
☐ Rehire
☐ Return from layoff
☐ Return from leave
☐ Loss of other group health coverage (not a special enrollment event for vision)
☐ Group annual enrollment
☐ Late applicant
☐ Birth, adoption/placement for adoption
☐ Marriage
☐ Change in work hours. Indicate number of hours per week you *were* working: _____ hours
☐ Divorce
☐ Change of Occupation:
Previous Occupation: _____
☐ Other: _____

Date that the event indicated above occurred (MM/DD/YYYY):_____

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Employee Name:_____

Section 4–Type of Coverage Selected

To determine which plan you are eligible for, please check with your employer.

☐ **Health** If multiple plans are offered, please indicate plan selected. _____

Type of Coverage: ☐ Single ☐ Family

☐ **Vision**

Type of Coverage: ☐ Single ☐ Family

Section 5–Waiver of Coverage (Please complete if you are eligible but NOT electing coverage)

Health Waiver

I understand that I am eligible to apply for group health coverage through my employer. I do NOT want, and hereby waive, group health coverage for:

☐Myself ☐ My spouse ☐ My domestic partner ☐ My dependent child(ren)

☐Me, my spouse/domestic partner and my dependent children

Reason for waiver:

☐ Persons listed above have other insurance ☐ Good health

☐ My earnings are such that I would have to pay more than 10% of my annualized gross earnings toward health insurance

I understand that if I do not apply for health coverage when initially eligible and instead apply later, I and my dependents may have to exhaust a 12-month waiting period before coverage is effective.

Signature: _____ Date: _____

Vision Waiver

Does your employer pay the full premium for your vision coverage? ☐ Yes ☐ No

Important Note: If Yes, you must enroll in the group vision plan. You may not waive coverage.

If No, and you choose not to elect coverage for you, your spouse/domestic partner, and/or your dependent children, please complete the following:

I understand that I am eligible to apply for group vision coverage through my employer. I do NOT want, and hereby waive, group vision coverage for:

☐Myself ☐ My spouse ☐ My domestic partner ☐ My dependent child(ren)

☐Me, my spouse/domestic partner and my dependent children

I understand that if I do not apply for vision coverage when initially eligible, I and my dependents may have to wait until my employer's annual open enrollment period to enroll later.

Signature: _____ Date: _____

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Employee Name:_____

Section 6 – Health Insurance and Medicare Information

Are your spouse/domestic partner or any of your dependent children disabled? ☐ No ☐ Yes

If Yes, please list name(s), nature of disability, and the Medicare number if applicable:

_____

_____

Will you or any family member(s) continue or maintain any other health insurance or self-funded group medical plan in addition to the coverage being applied for today? ☐ No ☐ Yes

If Yes, please complete the following:

Family Member Name	Subscriber Name (under other plan)	Insurance Company/Plan	Group Number	Type of Coverage	Effective Date of Coverage	Cancellation Date (if applicable)
1.				☐ Single ☐ Family		
2.				☐ Single ☐ Family		
3.				☐ Single ☐ Family		

Are you or any of your family members eligible for Medicare? ☐ No ☐ Yes

If yes, please complete the following or attach a copy of your Medicare card:

Name of person covered by Medicare:_____

Medicare Number:_____

Reason for Medicare Eligibility: ☐ Over age 65 ☐ End-Stage Renal Disease (ESRD) ☐ Total Disability

Effective Dates: Part A _____ Part B _____ Part C (Medicare Advantage) _____ Part D _____

Does a divorce decree affect insurance coverage for any dependent children covered by your Trust policy? ☐ No ☐ Yes

If yes, please send a copy of the portion of the divorce decree that stipulates health coverage.

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Employee Name: ____

Section 7–Dependent Information (Only list individuals enrolling)

Spouse/Domestic Partner Name (Last, First, Middle Initial) **Date of Birth** (MM/DD/YYYY) **Social Security Number**

Gender ☐ Male ☐ Female **Type of Coverage** ☐ Health ☐ Vision **Relationship** ☐ Spouse ☐ Domestic Partner

Dependent Name (Last, First, Middle Initial) **Date of Birth** (MM/DD/YYYY) **Social Security Number**

Gender ☐ Male ☐ Female **Type of Coverage** ☐ Health ☐ Vision **Relationship** ☐ Child ☐ Stepchild ☐ Legal Ward ☐ Other: ___________

Dependent Name (Last, First, Middle Initial) **Date of Birth** (MM/DD/YYYY) **Social Security Number**

Gender ☐ Male ☐ Female **Type of Coverage** ☐ Health ☐ Vision **Relationship** ☐ Child ☐ Stepchild ☐ Legal Ward ☐ Other: ___________

Dependent Name (Last, First, Middle Initial) **Date of Birth** (MM/DD/YYYY) **Social Security Number**

Gender ☐ Male ☐ Female **Type of Coverage** ☐ Health ☐ Vision **Relationship** ☐ Child ☐ Stepchild ☐ Legal Ward ☐ Other: ___________

Dependent Name (Last, First, Middle Initial) **Date of Birth** (MM/DD/YYYY) **Social Security Number**

Gender ☐ Male ☐ Female **Type of Coverage** ☐ Health ☐ Vision **Relationship** ☐ Child ☐ Stepchild ☐ Legal Ward ☐ Other: ___________

Dependent Name (Last, First, Middle Initial) **Date of Birth** (MM/DD/YYYY) **Social Security Number**

Gender ☐ Male ☐ Female **Type of Coverage** ☐ Health ☐ Vision **Relationship** ☐ Child ☐ Stepchild ☐ Legal Ward ☐ Other: ___________

Section 8–Signature and Authorization (Must sign and date if enrolling)

To the best of my knowledge, I agree that the information I have provided is true and accurate. If I elected vision coverage for myself and my dependents, I understand that I and my dependents may not voluntarily terminate vision coverage before my employer's annual open enrollment period that occurs after I and my dependents have been enrolled for a period of at least 12 consecutive months.

If either plan requires a salary deduction, I hereby authorize my employer to make all necessary deductions.

Signature **Date** (MM/DD/YYYY)