EAST MOLINE SCHOOLS
INSURANCE APPLICATION

(Health, Dental, Vision, Life/AD&D, Supplemental Life, LTD)

APPLICANT INFORMATION

Last Name:	MI:	First Name:

Date of Birth:	Social Security:	☐ Male
Email Address:		☐ Female

Address:	Apt#	City:	Zip:

State:	**Date of Hire:**	Effective Date:
Job Title:	Salary:	Hours Per Week:

REASON FOR ENROLLMENT/CHANGE (PLEASE MARK X IN APPROPRIATE BOX)

☐ New Hire	☐ Open Enrollment	☐ COBRA
☐ Loss of Coverage	☐ Birth/Adoption	☐ Other (Explain):

SPOUSE OR DOMESTIC PARTNER INFORMATION

Last Name:	MI:	First Name:
Relationship:	☐ Male	☐ Female
Social Security:	Date of Birth:	

DEPENDENT 1 INFORMATION

Last Name:	MI:	First Name:
Relationship:	☐ Male	☐ Female
Social Security:	Date of Birth:	

DEPENDENT 2 INFORMATION

Last Name:	MI:	First Name:
Relationship:	☐ Male	☐ Female
Social Security:	Date of Birth:	

DEPENDENT 3 INFORMATION

Last Name:	MI:	First Name:
Relationship:	☐ Male	☐ Female
Social Security:	Date of Birth:	

DEPENDENT 4 INFORMATION

Last Name:	MI:	First Name:
Relationship:	☐ Male	☐ Female
Social Security:	Date of Birth:	

COVERAGE SELECTED (Please mark an X for all that apply.
If you are waiving (declining) coverage, please place an X next to all that apply in the Waive section.

Coverage Requested	BC/BS Medical	Guardian Dental	UHC Vision	Guardian Basic Life, AD&D	Guardian Voluntary		
					LTD	Supp Life	Supp Dep Life
Employee	☐	☐	☐	X	☐	☐	
Spouse	☐	☐	☐				☐
Children	☐	☐	☐				☐
Waive	☐	☐	☐		☐	☐	☐

Class Selection. Please mark an X in appropriate box

☐ Class 1 Administrators	☐ Class 2 All Others

Supplemental Life Coverage: You must be enrolled to cover your dependents. Increments of $10,000 to a **max of $350,000**, not to exceed 5x Salary. Benefit reductions apply. Please see plan admin.						
Employee policy amount. Check one area only. The amount you choose will be the total amount in force. **Guarantee Issue amount*						
☐ $10,000	☐ $30,000	☐ $70,000	☐ $100,000	☐ $150,000	☐ **$200,000***	☐Other:

Supplemental Life Coverage for Spouse**.** **Increments of $10,000 to a max of $50,000 not to exceed 50% of the Employees Supp Life amount.**				
Check one area only. The amount you choose will be the total amount in force. **Guarantee Issue amount*				
☐ **$10,000***	☐ $20,000	☐ $30,000	☐ $40,000	☐ $50,000

Supplemental Life Coverage for Dependent/Child(ren)**. Infant Benefit: Birth to 6 months $500** Child ages 6 months to 19 yrs (to age 25 if full time student)	
Check one area only. The amount you choose will be the total amount in force. **Guarantee Issue amount*	
☐ $5,000	☐ **$10,000***
Important Notes: Based on your plan benefits and age, you may be required to complete an Evidence Of Insurability for Vol. Life	

Name Your Beneficiaries		
Primary Beneficiaries: (Primary beneficiary percentages must total 100%)		
Name:	Relationship:	%
Name:	Relationship:	%
Contingent Beneficiaries :(Contingent beneficiary percentages must total 100%)		
Name:	Relationship:	%
Name:	Relationship	%

Acknowledgement & Signature

I understand, agree, and represent that:

- I have read this document or it has been read to me.
- The answers provided within this entire application for coverage are, to the best of my knowledge and belief, true and complete.
- Neither my employer nor the agent has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, or waive any of the insurance carrier's other rights and requirements.
- I understand that if I intentionally omit or provide false information on or in relation to this application, then this policy may be cancelled retroactively, in which case any claim I submit may not be paid by the insurer. I understand that if I intentionally omit or provide false information on or in relation to this application that I may face legal liability, including legal action based on fraud.
- If this application for coverage is accepted, coverage will be effective on the date specified by the insurance carrier on the certificate of coverage/certificate of insurance.

I hereby enroll for benefits as indicated in this application, for which I am presently eligible or for which I may become eligible under my employer's group contract(s). If any deductions are required for this coverage, I authorize such deductions from my earnings. I reserve the right to revoke this deduction authorization at any time upon written notice.

I understand that the information I have provided in this application will be used by the insurance carrier and its affiliates to make decisions regarding eligibility, enrollment, underwriting, and premium risk rating.

I understand that the medical information provided also includes my spouse/domestic partner and/or dependents' information.

I understand that I may be asked for authorization to disclose my medical, claim, or benefit records at a later time.

I understand that I should retain a duplicate copy of this application for my own records.

A photographic copy of this acknowledgment shall be as valid as the original.

I authorize the insurance carrier to electronically transmit the information contained herein.

If this application was taken over the phone or on the computer, I acknowledge that I, myself, have not actually signed this application but instead hereby authorize the insurance carrier to print "Electronically Acknowledged" on the signature line of the application and I agree that such printing shall be treated as a valid signature for all purposes of this form. I acknowledge that the insurance carrier has verified my identity for this purpose in accordance with any applicable law or regulation.

By signing below, I acknowledge that I have read and understand this document and I am signing of my own free will.

Employee Signature:	Date: