PPi Benefit Solutions
ACSA Group Insurance Trust

Celebrate the Children
ENROLLMENT/CHANGE REQUEST FORM
Employer No. 039440

Mailing Address:
10 Research Parkway
Wallingford, CT 06492
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Section 1 – Plan Options

Please complete the following (Employer Use Only):

REQUIRED: Employee Annual Salary $____________

Payroll/Benefit Deduction Frequency: ______________

Select One: ☐ Management ☐ All Others

☐ **Cigna Medical–OAP Base Plan** ☐ S ☐ H/W ☐ P/C ☐ F
$20/$40 PCP/Specialist copay $1,500/$3,000 deductible

☐ **Cigna Medical–OAP High Plan** ☐ S ☐ H/W ☐ P/C ☐ F
$20/$40 PCP/Specialist copay
Out-of-Network $2,000/$4,000 deductible

☐ **Guardian Dental and Vision – Option 1 – DHMO**
☐ S ☐ H/W ☐ P/C ☐ F

☐ **Guardian Dental and Vision – Option 2 – NAP PPO**
☐ S ☐ H/W ☐ P/C ☐ F

☐ **Guardian Dental and Vision – Option 3 – Value PPO**
☐ S ☐ H/W ☐ P/C ☐ F

☑ **Guardian Life & AD&D**
☑ **Guardian LTD**

Guardian Voluntary Life Coverage:
Employee Life only ($25,000 increments to max of $250,000)
☐ Employee Life only: Amount $______________

Spouse/Life only (50% of Employee coverage to a max of $125,000)
☐ Spouse Life only: Amount $______________

Child Life only (10% of Employee coverage to a max of $10,000)
☐ Child Life only: Amount $______________

Section 2 – Type of Activity

*Employer ***must*** complete *both* of the following if enrolling or changing coverage:

***Date of Hire or Rehire:**

		-			-				

***Effective Date of Coverage:**

		-			-				

1. ENROLL FOR COVERAGE (List all enrollees in Section 3):
☐ New/Rehire
☐ Open Enrollment
☐ Part-time to Full-time status
☐ Loss of other coverage (HIPAA Cert from prior carrier required)
Date of Loss of Coverage: ______________

2. CHANGES TO COVERAGE
A. Add Dependents (List Deps in Section 3):
☐ Birth/Adoption
☐ Marriage
☐ Other (**specify**):____________________

Date of Event: ____________________

PLEASE NOTE THE FOLLOWING:
Provider Changes after your initial election must be reported directly to the insurance carrier.

B. Other Changes (Specify on form)
☐ Open Enrollment Plan Change
☐ Name Change
☐ Address Change
☐ Beneficiary Change

3. REMOVE COVERAGE
A. Cancel Dependents (List Deps in Section 3):
☐ Loss of Student Status
☐ Divorce/Separation
☐ Gained Other Coverage
☐ Death
☐ Other (**specify**):______________

Date of Loss: ______________

B. Term Employee Coverage
☐ Reduced Hours
☐ Gained Other Coverage
☐ Retirement
☐ Other (**specify**):__________________

Date of Loss: ______________

To *Terminate ALL employee coverage*, please use PPI's *Employer Change Report*.

Section 3 – Individuals Covered (A=Add C=Change R=Remove)

EMPLOYEE:

Last Name	First Name	**SS#** ___ ___ ___ — ___ ___ — ___ ___ ___ ___
Home Address	City	State / Zip
Date of Birth __ __ / __ __ / __ __ __ __	Gender: ❑ M ❑ F	Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Other
Occupation:		
Medical: ❑ A ❑ C ❑ R	Provider ID #	Existing Patient: Yes ❑ No ❑
Dental: ❑ A ❑ C ❑ R	Provider ID# (if DHMO checked in Section 1):	Existing Patient: Yes ❑ No ❑
Vision: ❑ A ❑ C ❑ R	Voluntary Life: ❑ A ❑ C ❑ R	

SPOUSE (SSN Required if Electing coverage):

Last Name	First Name	**SS#** ___ ___ ___ — ___ ___ — ___ ___ ___ ___
Date of Birth __ __ / __ __ / __ __ __ __	Gender: ❑ M ❑ F	Domestic partner? ❑ No ❑ Yes (Complete separate declaration form)
Medical: ❑ A ❑ C ❑ R	Provider ID #	Existing Patient: Yes ❑ No ❑
Dental: ❑ A ❑ C ❑ R	Provider ID# (if DHMO checked in Section 1):	Existing Patient: Yes ❑ No ❑
Vision: ❑ A ❑ C ❑ R	Voluntary Life: ❑ A ❑ C ❑ R	

CHILD (SSN Required if Electing coverage):

Last Name	First Name	**SS#** ___ ___ ___ — ___ ___ — ___ ___ ___ ___
Date of Birth __ __ / __ __ / __ __ __ __	Gender: ❑ M ❑ F	Full-time Student? ❑ No ❑ Yes (Complete Section 4)
Medical: ❑ A ❑ C ❑ R	Provider ID #	Existing Patient: Yes ❑ No ❑
Dental: ❑ A ❑ C ❑ R	Provider ID# (if DHMO checked in Section 1):	Existing Patient: Yes ❑ No ❑
Vision: ❑ A ❑ C ❑ R	Voluntary Life: ❑ A ❑ C ❑ R	Handicapped Child? ❑ No ❑ Yes (Separate form may need to be completed)

CHILD (SSN Required if Electing coverage):

Last Name	First Name	**SS#** ___ ___ ___ — ___ ___ — ___ ___ ___ ___
Date of Birth __ __ / __ __ / __ __ __ __	Gender: ❑ M ❑ F	Full-time Student? ❑ No ❑ Yes (Complete Section 4)
Medical: ❑ A ❑ C ❑ R	Provider ID #	Existing Patient: Yes ❑ No ❑
Dental: ❑ A ❑ C ❑ R	Provider ID# (if DHMO checked in Section 1):	Existing Patient: Yes ❑ No ❑
Vision: ❑ A ❑ C ❑ R	Voluntary Life: ❑ A ❑ C ❑ R	Handicapped Child? ❑ No ❑ Yes (Separate form may need to be completed)

Please use a separate sheet of paper for additional dependents.

Please continue on the reverse side

Section 4 – Student Status Information for Non-Medical Plans

Generally, dependents over the age of 18 must be full-time students to be eligible for non-medical coverage. Please list below all full-time students from Section 3. Include the name of the school and the student's expected date of graduation. Use a separate sheet of paper for additional students.

Dependent Name: ____________________	Dependent Name: ____________________
Name of School: ____________________	Name of School: ____________________
Expected Graduation Date: ____________________	Expected Graduation Date: ____________________

Section 5 – Life Insurance Beneficiary Designation

Primary Beneficiary Name(s)	SS#	Relationship	Date of Birth	% of Benefit (whole #'s)
	— —		/ /	
	— —		/ /	
	— —		/ /	
Contingent (if primary deceased)				
	— —		/ /	
	— —		/ /	

Section 6 – Waiver of Coverage (Complete and sign ***ONLY*** if waiving coverage(s) for yourself and/or your dependents)

I hereby certify that I have been given an opportunity to enroll for Group Health Insurance benefits offered by my employer and have decided **NOT** to enroll in the following coverage(s):

☐ Medical ☐ Dependent Medical ☐ Dental ☐ Dependent Dental ☐ Vision ☐ Dependent Vision
☐ Voluntary Life (EE) ☐ Voluntary Life (SP) ☐ Voluntary Life (CH)

I understand that if I desire such insurance hereafter, I shall be required to wait for my employer's open enrollment period to enroll for Medical coverage for myself and for all my eligible dependents.
I also understand that if I delay enrolling more than 31 days after the date I could first become insured, the Dental benefits for myself and my dependents may be limited for a period time as determined by the plan rules.
I understand that if I delay enrolling more than 31 days after the date my dependents and myself first become eligible for Voluntary Life, evidence of insurability will apply.

____ ______/_____/______
Employee's Signature Date

Section 7 – Employee Signature

I represent that all the information supplied in this application is true and complete. I have personally designated the beneficiaries shown on this form (if applicable) and hereby request group insurance for myself and for my dependents listed on this form for selected coverages noted in Section 1. I hereby authorize my employer or successor to make deductions from my earnings of the required contributions, if any, to apply toward the insurance costs for the insurance provided for in the policy of group insurance issued to my employer.

I understand that the effective date of insurance for myself or for any of my dependents is subject to my being actively at work on that date and that the effective date of insurance for any of my dependents is also subject to the dependent health condition requirements of the Plan. Further, I understand that any insurance subject to evidence of good health or medical information will not become effective until the carrier gives its written consent.

I understand that, in the event I fail to sign this form within 31 days of the effective date of eligibility or that for any reason the carrier does not receive notice of the Enrollment/Change Request within a reasonable time following the event, my eligibility and my dependent's eligibility may be affected.

Misrepresentations: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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 and subjects such person to criminal and civil penalties.

____ ______/_____/______
Employee's Signature Date

Section 8 – Employer Verification

Employer's Signature	Title	Date

IMPORTANT Before signing this form, please review it for accuracy and completeness. Incomplete forms will be held pending for missing information resulting in a delay in processing. Should you need assistance, please contact PPI's account service team at (888) 674-0046. All enrollment forms should be faxed to (203) 793-1210 or emailed to FaxesBE@ppibenefits.com.