~~ENROLLMENT FORM~~

2021 WAIVER FORM

Employer Information

Employer Name	Group Number	Date of Hire	~~Effective Date~~
A-1 Personnel of Houston	FCR8619		

Employee Information

Last Name	First Name	Gender ☐ Male ☐ Female	Social Security #
Date of Birth	~~Salary~~	~~Occupation~~	
Address	City	State	Zip
Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Separated	Email Address	Phone Number	Reason for Enrollment ☐ Open Enrollment ☐ New Hire ☐ Family Status

Medical Coverage Options

MEC Basic Plan ☐ Enroll ☑ Waive Coverage	**Coverage Tier** ☐ Employee ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family
MEC Plus Plans ☐ Value Plan ☐ Select Plan ☑ Waive Coverage	
Minimum Value Plan (MVP) - Bronze ☐ Enroll ☑ Waive Coverage	

Life and/or AD&D Insurance Beneficiary Designation

Beneficiary Name	Date of Birth	Relationship

Dependent Information

Last Name	First Name	Gender	Social Security #	Date of Birth
Spouse		☐ Male ☐ Female		
Dependent		☐ Male ☐ Female		
Dependent		☐ Male ☐ Female		
Dependent		☐ Male ☐ Female		

FRINGE BENEFIT GROUP (888)798-9480

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Current/Prior Coverage

Have you or your dependents been covered under this employer's plan or any other major medical plan(s) at any time in the past 12 m[illegible]ths? ☐ Yes ☐ No

If yes, who [illegible]vered? ☐ Employee [illegible]pouse ☐ Child(ren)	Nam[illegible] Carrier	[illegible]licy/ID#	Effe[illegible] Date
Will prior coverage [illegible] in [illegible]e when coverage under this employer's plan goes in[illegible]ffect? ☐ Yes ☐ No			If no, what is the term date?

Qualified Medical Child Support Order

Are any of your d[illegible]ndents co[illegible]d by a Qualified Medical Child Support Order? [illegible] ☐ Yes [illegible]o (if yes, complete below)

Custodial Par[illegible]	N[illegible] of Dependent	Dependent's So[illegible]ecurity #	[illegible]endent's Date of Birth	
Dependent's Residential Address		City	State	Zip

Waiver of Coverage

I elect to waive coverage for myself? ☐ Yes Reason:

I elect to waive coverage for my dependents? ☐ Yes Reason:

Name(s) of Dependent(s) for which to waive coverage:

Signature	Date

Employee Agreement

I hereby apply for participation in my employer's Employee Health and Welfare Benefit Plan for myself and/or my dependents listed above and ag[illegible]e to abide by the terms, p[illegible]visions, and limitations as outlined by the Plan Sponsor in the issu[illegible]ce of the Plan Summary Desc[illegible]n. I declare all statem[illegible] contained in this form are true and [illegible]ect and that no mate[illegible]nformation has been withheld or o[illegible]d. I understand [illegible] any misstatements or failure to report info[illegible]tion that is mate[illegible]o my qualification and particip[illegible] may be [illegible] as a basis for rescission of my participation and[illegible]enial of p[illegible]ent of claims. I agree no benefits will be effe[illegible] un[illegible] date specified at the top of this form.

I hereby authorize any licensed [illegible]an, medical practitioner, hospital, clinic or other medical or [illegible]ally related facility, the Veterans Administration, the [illegible]ca[illegible]mation Bureau (MIB), or any other organization, institu[illegible] ins[illegible]ce or reinsurance company, to disclose and [illegible]ase any i[illegible]ation in its possession about the medical history[illegible]tal or p[illegible]l condition or treatments of myself an[illegible] my dependen[illegible] Fringe Benefit Group or its designee. A pho[illegible]atic copy of th[illegible]thorization shall be considered [illegible]ective and valid as [illegible]riginal.

Signature	Date