

WAIVER OF COVERAGE

The group **medical program** has been offered to me, and after carefully considering its benefits, I have decided:

- (a) not to enroll myself in the Medical Program
 - (1) I was covered as a Dependent Spouse in another Group Plan when I became eligible for this Plan.
 - (2) I had other Creditable Coverage when I became eligible for this Plan.
 - (3) I do not have other Creditable Coverage

I understand that if I elect not to enroll in the **group medical program** at this time I will not be permitted to enroll at a later date unless:

- (1) A person becomes my dependent through marriage, birth, adoption or placement for adoption and I request enrollment for myself and my dependent(s) within 31 days of such event; **OR**
- (2) each of the following conditions is met:
 - (a) I have declined this coverage on the basis of item (a)(1) or item (a)(2) above; and
 - (b) my coverage is terminated as a result of loss of eligibility for the coverage (for reasons other than fraud or failure to pay premiums); and
 - (c) I request enrollment within 31 days of the loss of coverage.

- (b) not to enroll my dependents in the Medical Program
 - (1) My Dependents are covered in another Plan
 - (2) My Dependents are not covered in another Plan

I understand that if I elect not to enroll my eligible Dependents in the **group medical program** at this time I will be permitted to enroll them at a later date only if each of the following conditions is met:

- (1) I am a participant under this Plan; and
- (2) A person becomes my Dependent through marriage, birth, adoption or placement for adoption (all other Dependents must be enrolled at the same time) **OR** I had waived coverage on the basis of item (b)(1) above and my Dependent or Dependents lose coverage as a result of loss of eligibility under that coverage; and
- (3) I request enrollment of such person or persons within 31 days of the qualifying event.

I understand that if the other coverage is lost as a result of the failure to pay premiums or required contributions or for cause (such as making a fraudulent claim) these options will not be granted.

Employee Signature

Date Signed

Employee Printed Name



KANAWHA
HealthCare
SOLUTIONS, INC.

General Synod of the Associate Reformed Presbyterian Church
Group Dental Enrollment Form

Submit Form To
Associate Reformed Presbyterian Center
1 Cleveland Street, Suite 110
Greenville, SC 29601-3696

PLAN NUMBER: GAR0801					
A. Employer Information					
Employer Name/Company Name (Please Print) AGENCY or CHURCH: _____				County	State
B. Employee Information					
Social Security Number		Last Name		First Name	MI
Street Address			City	State	Zip
Date of Birth		Spouses Date of Birth		Home Phone ()	Work Phone ()
<input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed				
C. Employment Information					
Occupation: _____		Date of Full-Time Employment: _____		Average Hours Worked Per Week: _____ <input type="checkbox"/> Salaried <input type="checkbox"/> Hourly	
D. Coverage Category: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee Plus 1 <input type="checkbox"/> Family <input type="checkbox"/> None (Complete Waiver)					
E. Eligible Dependents to be Enrolled (To be Completed by Employee)					
Name		Reside With Employee	Sex	Date of Birth	Social Security #
Spouse:		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Child:		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Child:		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Child:		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Child:		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Child:		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Child:		<input type="checkbox"/> Yes <input type="checkbox"/> No			
F. Other Coverage Information (To be Completed by Employee)					
Are you or any member of your family covered by any other dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If Yes, Name of Carrier: _____					
Policy ID # _____					
Address _____					
Policy Holder Name: _____					
Are Family Members Covered: <input type="checkbox"/> Yes <input type="checkbox"/> No					
G. Acceptance and Authorization for Coverage and Participation: I certify that the above information is correct and true to the best of my knowledge and that the children listed above either live with me in a normal parent-child relationship or are legally dependent upon me for their support. I hereby authorize any hospital or physician to release information to process claims on myself and any dependents on this Plan.					
Employee's Signature: _____			Date Signed: _____		
H. Refusal: The benefits have been explained to me and I have refused to participate in the plan. I have signed the attached Waiver of Coverage.					
Employee's Signature: _____			Date Signed: _____		
I. Employer Certification: The above information is correct and true to the best of my knowledge.					
Employer's Representative Signature: _____			Date Signed: _____		
J. Coverage Information (To be Completed by Group Administrator, Board of Benefits)					
Effective Date of Coverage: _____		Experience Category			
Was Subject to 90 Day Waiting Period: <input type="checkbox"/> Yes <input type="checkbox"/> No		_____			
Hire Date: _____					
K. Group Administrator Certification: The above information is correct and true to the best of my knowledge.					
Group Administrator's Signature: _____			Date Signed: _____		

WAIVER OF COVERAGE

The group **dental program** has been offered to me, and after carefully considering its benefits, I have decided:

- (a) not to enroll myself in the Dental Program
 - (1) I am covered as a Dependent Spouse in another Plan
 - (2) I had other Creditable Coverage when I became eligible for this Plan
 - (3) I am not covered in another Plan
- (b) not to enroll my dependents in the Dental Program
 - (1) My Dependents are covered in another Plan
 - (2) My Dependents are not covered in another Plan

I understand that if I do not enroll myself and/or my eligible Dependents in the **group dental program** at this time and do not meet the eligibility for **Special Enrollment**, as outlined below,

- (1) I will be able to enroll and/or add dependents only during the **group dental program** Open Enrollment period, currently in December for coverage to begin January 1 **and**
- (2) benefits during the first 12 months of coverage will be limited to initial and periodic exams, x-rays, cleanings and fluoride applications only.

Special Enrollment: In the event a person becomes my Dependent through marriage, birth, adoption or placement for adoption (all other Dependents must be enrolled at the same time) **OR** I had waived coverage on the basis of item (b)(1) above and my Dependent or Dependents lose coverage as a result of loss of eligibility under another group plan and

I request enrollment of such person or persons within 31 days of the qualifying event, enrollment will be permitted at the time of such occurrence and restrictions on coverage will not apply.

I understand that if the other coverage is lost as a result of the failure to pay premiums or required contributions or for cause (such as making a fraudulent claim) these options will not be granted.

Employee Signature

Date Signed

Employee Printed Name



**ENROLLMENT FORM FOR EMPLOYEE AND DEPENDENT
LIFE, ACCIDENTAL DEATH & DISMEMBERMENT, and
LONG TERM DISABILITY
General Synod of the Associate Reformed Presbyterian Church**

Please Use Ink or Type GROUP POLICY NUMBER: TM05585382 0001

A. Employee Information

Church or Agency of Employment: (Please Print) County State

Social Security Number Last Name First Name MI Date of Birth

Male Married Divorced Home Phone Work Phone Email Address
 Female Single Widowed () ()

Street Address or Post Office Box City State Zip Code

B. Dependent Information: (All Dependents 6 months and older have \$2,000 Term Life. Please list, if appropriate, your Spouse and Dependent Children)

Name of Spouse or Dependent (Last, First, MI)	Relationship	Date of Birth

C. Beneficiary Information for Employee Insurance (Dependent Insurance is Payable to the Employee). The Employee signing below names the following person(s) as primary beneficiary (ies) for any payment upon his or her death. Unless designated otherwise, payments will be made in equal shares or all to the survivor. The Employee understands that he or she has the right to change this designation at any time.

Primary Beneficiary (ies) Full Name (Last, First, MI)	Relationship	Date of Birth	Address (If Different from Above)

Contingency Beneficiary (ies) Full Name (Last, First, MI)	Relationship	Date of Birth	Address (If Different from Above)

D. Declaration Section: Each person signing below declares that all the information given in this enrollment form is true and complete to the best of his/her knowledge and belief. Each person understands that this information will be used by MetLife to determine his or her eligibility.

Fraud Warning: If you reside in or are applying for insurance under a policy issued in one of the following states, please read the applicable warning. **New York** (Only applies to AD&D and Disability): 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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. **Florida:** Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or

