



First Administrators, Inc. Medical Enrollment Form

Account No. 92400

A. Employee Information

New Enrollee Change Special Enrollment

Your name (last, first, middle initial)				Social Security Number		
Address		City	State	Zip	Phone Number	
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Widowed	<input type="checkbox"/> Married <input type="checkbox"/> Divorced	<input type="checkbox"/> Legally Separated <input type="checkbox"/> Domestic Partner		

B. Dependent Information: List your spouse/partner and all eligible dependent children.

Name of Spouse/Partner	Social Security Number	Sex	Date of Birth			
Name(s) of Eligible Dependent Children	Social Security Number	Date of Birth	Sex	Full-Time Student	Foster Child	Step Child
1.						
2.						
3.						
4..						

Foster child and stepchild eligibility is subject to approval. Complete form DRK4
 If you have developmentally disabled/physically handicapped children, complete form DRK5. Eligibility is subject to approval.
 In order to ensure network benefits, you must notify Human Resources of any change of address of your dependent during the plan year. Complete form DRK6.

C. Benefit Election

I elect coverage for:*	<input type="checkbox"/> Myself Only	<input type="checkbox"/> Myself, Spouse/Partner and Child(ren)
	<input type="checkbox"/> Myself and Spouse/Partner	<input type="checkbox"/> Myself and Child(ren)
*If you do not elect coverage for yourself and all eligible dependents, read and complete Section D below.		
I declare I am eligible to enroll in this plan and request to be covered. If the group plan provides that contributions be made by me, I authorize my employer to deduct them from my pay. I hereby declare that, to the best of my knowledge and belief, the information given on this enrollment form is correctly recorded, complete and true.		
Please be sure form is complete so enrollment is not delayed.		
Signature of employee (Please do not print)		Date signed

D. Refusal of Coverage

I hereby acknowledge that I have been given an opportunity to apply for Medical coverage offered by Drake University for which I am eligible. If I am not applying for the Medical coverage for which I am eligible, I understand the benefits available under the plan and I DECLINE to enroll	
because <input type="checkbox"/> Myself <input type="checkbox"/> My Spouse/Partner <input type="checkbox"/> My Children	
I UNDERSTAND if I refuse any coverage under the plan	
(a) My Dependent(s) are not eligible for any coverage for which I am not insured.	
(b) I have read and understand my rights about the Preexisting Condition Exclusion and Special Enrollment Rights.	
(c) If I decline Medical coverage, I and/or my dependents must wait until the next annual open enrollment period to enroll, unless I become eligible for Special Enrollment Rights.	
Signature of employee (Please do not print)	
Date signed	

E. Employer to Complete this Section

Date Employed	Payroll Effective Date	Employee Effective Date	Dependent Effective Date