Group Resources, Inc.
P.O. Box 100043
Duluth, GA 30096-9343

BENEFIT ENROLLMENT FORM

RATE CODE: ____________

FOR EMPLOYER USE ONLY: Hire Date: ____________ Eff. Date: ____________

EMPLOYER NAME: ____________ Amount of Life $ ____________

SECTION I - EMPLOYEE INFORMATION

Last Name: ____________ First: ____________ Initial ____

Soc. Sec. #: ____________ Sex: ____ Date of Birth: ____________ Job Title: ____________

Address: ____________

City: ____________ State: ____________ Zip: ____________

SECTION II - COVERAGE INFORMATION

SINGLE
- ☐ Medical
- ☐ Dental
- ☐ Vision
- ☐ I Decline Coverage

FAMILY
- ☐ Medical
- ☐ Dental
- ☐ Vision
- ☐ I Decline Coverage

PLAN INFORMATION
- ☐ Deductible ____________
- ☐ Hourly/Salary ____________
- ☐ Plan Option ____________
- ☐ Life Only ____________
- ☐ I elect Dependent Life ☐Yes ☐ No

Reason for Declination ____________

If you Elect dependent coverage, please complete section below.

Dependent Name	Soc. Sec. #	Sex	Date of Birth	Relationship

SECTION III - YOUR PLAN OPTIONS (See Attached Schedule)

I Elect Plan Option(s) ____________ Signature: ____________ Date: ____________

I Decline Coverage ____________ Signature: ____________ Date: ____________

I understand that in the event I, or my dependents, desire group insurance coverage in the future, I will be required to furnish at my expense, evidence of good health satisfactory to the Insurance Carrier, and my applying for coverage will not mean that coverage will automatically be granted

SECTION IV - YOUR APPROVAL FOR IRS CODE SECTION 125

I hereby apply for coverage under the benefit plan above. I authorize my employer to reduce my compensation as may be necessary to provide the benefits I selected on a pre-tax basis as permitted by IRS Code Section 125. I understand this agreement shall be effective for the plan year ending ____________ ____________. This agreement may not be amended as to the plan type during the plan year, except as permitted by IRS Code Section 125.

SIGNATURE: ____________ DATE: ____________

SECTION V - YOUR BENEFICIARIES

List your life insurance beneficiaries below. Designated beneficiaries will be paid equally unless otherwise indicated.

Beneficiary Name	%	Relationship		Beneficiary Name	%	Relationship

SECTION VI - YOUR APPROVAL

I hereby request my employer to arrange for benefits which I have elected. I authorize my employer to make the proper deductions (if any) from my earnings as my contribution toward the cost of this Plan.

SIGNATURE: ____________ DATE: ____________

Are you Covered by any other Plan? [ ] Yes [ ] No

Any Group Insurance, Blue Cross-Blue Shield or other pre-payment arrangement maintained on a group basis? [ ] Yes [ ] No

Any other coverage provided by an employer or any federal, state, or other government agency? [ ] Yes [ ] No

If "Yes" please furnish name and address of employer, insurance company or governmental agency, type of coverage and policy number.

____

____

____

If eligible, is person enrolled in :

Federal Medicare Part A [ ] Yes [ ] No

Effective Date of Part A is: ____________

Federal Medicare Part B [ ] Yes [ ] No

If "Yes", Effective Date of Part B is: ____________

IMPORTANT: THE FOLLOWING AUTHORIZATION MUST BE COMPLETED

To all physicians, hospitals, clinics, dispensaries, sanitoria, druggists, and all other agencies (including other insurance companies, Blue Cross-Blue Shield): You are authorized to permit Group Resources, Inc. or its representative to obtain or view a copy of your records pertaining to the examination, treatment, history, prescriptions and medical expenses of the patient identified above.

Such information may be used to the extent deemed necessary by Group Resources, Inc. to determine the value or amount payable on account of this claim.

Signature of Insured: ______________________________ Date: __________

Signature of Spouse: ______________________________ Date: __________

Patient's Signature: ______________________________ Date: __________

(Parent if Patient is Minor)