

Great-WestSM
HEALTHCARE
Instructions

1. Determine whether you want to enroll, decline coverage, or change information and complete the corresponding box.
2. Complete the section entitled “*General Information.*”
3. If you have life coverage, complete the beneficiary information in the section entitled “*Life Insurance.*”
4. If you are electing medical or dental coverage, complete the sections entitled “*For all Coverages*” and “*Medical Coverage.*”
 - If you select the POS plan, be sure to select a Primary Care Physician (PCP) for yourself and each covered dependent. Your PCP can provide most medical services and can assist with hospital and specialist recommendations.
 - If you select the PPO plan, do not supply provider information.If you need help selecting a PCP, contact Member Services.
5. Read the “*Disclosure Information*” on the back of the application.
6. Sign and date the application.
7. Remove this instruction card, make a copy of the application for your records and turn in the completed application to your plan administrator.

We look forward to meeting your family's health care needs.

Great-West Healthcare refers to products and services provided by Great-West Life & Annuity Insurance Company and its subsidiaries (Alta Health & Life Insurance Company and Great-West Healthcare HMO/HCSC companies). It also refers to the group business that is underwritten by New England Life Insurance Company and Metropolitan Life Insurance Company which is currently administered by Great-West Life & Annuity Insurance Company. Great-West Life & Annuity Insurance Company is not licensed to do business in New York. Products are sold in New York by its subsidiary First Great-West Life & Annuity Insurance Company, White Plains, N.Y.

Benefit Plan Enrollment/Change Form

ENROLLING				DECLINING COVERAGE		CHANGING INFORMATION																																																					
Enrollment for: <input type="checkbox"/> Myself and my dependents (family coverage) <input type="checkbox"/> Myself only (single coverage) because: <input type="checkbox"/> I have no dependents <input type="checkbox"/> My dependents have other insurance <input type="checkbox"/> I don't wish to purchase dependent coverage		Plan Selections: <table style="width: 100%; border-collapse: collapse;"> <tr> <th style="text-align: left;">Medical</th> <th>Ee</th> <th>Ee & Sp</th> <th>Ee & Ch</th> <th>Family</th> <th style="text-align: left;">Dental</th> <th>Ee</th> <th>Ee & Sp</th> <th>Ee & Ch</th> <th>Family</th> </tr> <tr> <td>POS</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Dental+</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>PPO</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Indemnity Dental</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>HRA PPO</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>POS Dental</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>HDHP-HSA</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>				Medical	Ee	Ee & Sp	Ee & Ch	Family	Dental	Ee	Ee & Sp	Ee & Ch	Family	POS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dental+	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PPO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Indemnity Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HRA PPO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	POS Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HDHP-HSA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						Reason: <input type="checkbox"/> I have other insurance <input type="checkbox"/> Other _____ My signature below certifies that I understand the availability of health coverage.		<input type="checkbox"/> Updating General Information <input type="checkbox"/> Transferring to a different plan <input type="checkbox"/> Changing PCPs <input type="checkbox"/> Adding a dependent	
Medical	Ee	Ee & Sp	Ee & Ch	Family	Dental	Ee	Ee & Sp	Ee & Ch	Family																																																		
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To be Completed by Employer																																																											
General Information (always complete this section)				Life Insurance																																																							
Name Last		First		MI		Occupation		If your employer is paying the full cost for this coverage, you are automatically covered under this benefit.																																																			
Street		Daytime Telephone (____)_____		Evening Telephone (____)_____		Email address																																																					
City		State		Zip Code		<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 33%;">Beneficiary</th> <th style="width: 33%;">Relationship</th> <th style="width: 33%;">%</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td></td> <td></td> </tr> <tr> <td>2.</td> <td></td> <td></td> </tr> <tr> <td>3.</td> <td></td> <td></td> </tr> </tbody> </table>		Beneficiary	Relationship	%	1.			2.			3.			Date of Full-time Employment		Div/Location																																					
Beneficiary	Relationship	%																																																									
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Social Security Number				Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Date of Marriage _____/_____/_____		Orig. Eff. Date of EE's Coverage		Orig. Eff. Date of Dep's Coverage																																																	
Earnings \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-Monthly <input type="checkbox"/> Yearly Hours worked per week? _____								Is employee/dependent on COBRA continuation? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, attach copy of original COBRA enrollment form.																																																			
For Carrier Use Only																																																											
Plan Number				Effective Date																																																							
Division		Late App		Class/Benefit Group																																																							
For all Coverages				Medical Coverage																																																							
Name (Last, First, M.I.)		Date of Birth/Relationship		Sex		Full-time Student		Primary Care Physician (Last, First, M.I.) Please list name(s) exactly as they appear in the directory				Existing Patient?																																															
Self		/ /		<input type="checkbox"/> M <input type="checkbox"/> F				PCP		Medical Group		<input type="checkbox"/> Yes <input type="checkbox"/> No																																															
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By my signature below, I acknowledge that I have read and understand the disclosure on the back of this application. I authorize the required payroll deduction for contributory benefits. I also represent that all information shown on this application is correct.																																																											
Employee Signature										Date (MM/DD/YYYY)																																																	

Disclosure Information

I hereby apply for all non-contributory coverages under my employer's plan and any contributory coverages that I have elected on the front of this application.

Life and/or disability income coverage

I understand that I must satisfy the eligibility and actively at work requirements at my employer's usual place of business on the date coverage for myself and any eligible dependents becomes effective. If I am not actively at work, I understand that coverage for myself and life coverage for my eligible dependents may not become effective until I return to work. I will be considered a late applicant if I decline any contributory coverage offered under this application and later apply. As a late applicant applying for coverage, I understand that proof of good health may be required for myself and eligible dependents.

HSA Pre-enrollment Statements

WARNING: You cannot open an HSA if, in addition to coverage under an HSA-qualified High Deductible Health Plan ("HDHP"), you are also covered under a Health FSA or an HRA or any other health coverage that is not an HDHP.

By checking the HDHP-HSA box in this Medical Enrollment Form, I express my intent to open a Health Savings Account (HSA) with Mellon Trust of New England, N.A., an HSA service provider arranged by Great-West Healthcare ("Great-West") or any other successor HSA service provider arranged by Great-West (hereafter "the HSA Service Provider"). The HSA Service Provider will contact me and provide me with an HSA enrollment form, a signature card, a request for information for a Customer Identification Program compliance and other related materials necessary to activate an HSA account with the HSA Service Provider.

I understand that, in order for my HSA opened with the HSA Service Provider to become operational, I must: 1) in a timely manner, complete, sign and submit all the forms required by the HSA Service provider; and 2) be found to meet all of the requirements prescribed by the HSA Service Provider.

However, if my employer has **not** selected Mellon Trust of New England, N.A. as the HSA service provider, I express my intent to open the HSA with an HSA custodian/trustee that is either arranged by my employer or that I personally select. I agree to complete necessary forms and meet the requirements set forth by the HSA custodian/trustee to enable my HSA to become operational.

I understand that, with respect to my HSA opened pursuant to this arrangement, the HSA trustee/custodian will be solely responsible for all HSA services, transactions and activities related thereto. Neither my employer nor Great-West is responsible for any aspects of the HSA services, administration and operation.

I certify that I have enrolled or plan to enroll under an HDHP and am not covered under any other health coverage that is not an HDHP.

HRA PPO Plan

HRA coverage can only be chosen together with the HRA PPO Plan option. Your HRA coverage is self-funded by your employer, who is solely responsible for contributing the funds used to pay HRA benefits. You are not required to make any contribution to the HRA account, either pursuant to a salary deduction election or otherwise under a Section 125 cafeteria plan (except that contributions are required from those under COBRA continuation coverage). You may not enroll under this option if you are considered self-employed (including partners and more-than-2% shareholders in a subchapter S corporation).

Health coverage

I understand that I must submit a Certificate or evidence of prior creditable coverage to receive credit towards the satisfaction of any pre-existing condition limitation specified in my employer's plan; and to be eligible for credit, the gap between the two coverages must be 63 days or less.

I and/or my eligible dependent(s) will be considered a "Special Applicant" if:

- I did not previously elect to cover myself and/or my eligible dependent(s) under my employer's policy/plan because of other health coverage and I later apply because the other coverage terminated due to exhausting the maximum of COBRA coverage or due to loss of eligibility for coverage due to legal separation, divorce, death, termination of employment or reduction in the number of hours of employment; or
- I did not previously elect to cover myself and/or my eligible dependent(s) and I later apply for coverage because of a change in my family status resulting from marriage, birth or adoption or placement for adoption of a child, or a court has ordered me to provide coverage for my dependents; or
- My employer offers multiple health plans and I have decided to elect a different plan during the open enrollment period.

I understand that to qualify as a "Special Applicant" I must apply for health coverage for myself and/or my eligible dependent(s) within 31 days after:

- Coverage under the prior health plan ends; or I marry; or I acquire a new child through birth, adoption or placement of a child for adoption.

I will be considered a late applicant if:

- I fail to qualify as a "Special Applicant" because I did not apply within the 31 days as specified above; or
- I did not previously elect to cover myself and/or my eligible dependents and I later apply.

As a late applicant applying for health coverage, I realize that I may only be allowed entrance to the plan during the open enrollment period. As a late applicant, I realize that my entry to the plan may be subject to special enrollment requirements and that I must contact my Plan Administrator for details.

For all coverages

I hereby authorize any insurance company, health care provider, or other entity or person having knowledge of anyone listed on this application to give this new carrier or their designated agent(s) any and all records pertaining to such person's medical history for purposes of review, investigation or evaluation. For application purposes, this authorization is valid for 30 months from the date I sign it. For purposes of claims, reimbursement and receipt of services rendered, this authorization is valid during the term of such person's coverage for evaluation of the nature and medical necessity of the services received. I am, or my authorized representative is, entitled to a copy of this signed authorization.

California residents - I understand that any differences between myself (and/or my dependents) and Great-West Healthcare, including any claim of medical malpractice, will be resolved through Great-West Healthcare's grievance process, up to and including binding arbitration. Under this coverage, both the member and Great-West Healthcare are giving up the right to have differences decided by jury trial or by a court, except as state law provides for judicial review of arbitration proceedings. Any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Colorado residents - It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

New Jersey residents - Different providers in our network have agreed to be paid in different ways by us. Your provider may be paid each time she or he treats you (fee for service). These payment methods may include financial incentive agreements to pay some providers more (bonuses) based on many factors; member satisfaction, quality of care, and control of costs and use of services among them. If you desire additional information about how our primary care physicians or any other providers in our network are compensated, please call Member Services at the telephone number shown in your enrollment kit.

Florida residents - (1) I have received educational material regarding Advance Directives from Great-West Healthcare of Florida, Inc. as required by state regulations. I understand that if I wish to have Advance Directives I need to contact my primary care physician and supply him/her with a copy of my wishes. I can receive more education about Advance Directives by contacting my primary care physician. (2) Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Residents of all other states - Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

This Disclosure Information forms a part of the Application for Membership as fully as if it were contained over the applicant's signature.

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Arkansas residents - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

District of Columbia residents - WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Kentucky residents - 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.

Louisiana residents - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine residents - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

New Jersey residents - Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico residents - ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

Ohio residents - Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma residents - WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon residents – Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

Pennsylvania residents - 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.

Virginia residents - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.