WESTERN MUTUAL INSURANCE COMPANY, P.O. BOX 572450, MURRAY, UT 84157-2450

HEALTH INSURANCE ENROLLMENT FORM - **TYPE OR PRINT CLEARLY**

Name of Person to be Insured Last First Initial | Social Security # | Date of Birth | Home Phone ( )

Home Address City State Zip

Name of Employer Business Phone ( ) Date of Hire Monthly Hours Worked

Employee Gender: ☐ Male ☐ Female **Marital Status:** ☐ Married ☐ Single

Name of Spouse : Last First Initial Date of Birth Social Security #

Names of Dependent Children	**Date of Birth**	**Sex**	**Social Security #**

Type of Coverage: ☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child ☐ Employee & Children ☐ Employee, Spouse & Child(ren)

Medical: ____________________

Dental: ☐ Yes ☐ No **Vision**: ☐ Yes ☐ No

Disability: ☐ Yes ☐ No

For Office Use Only

Effective Date: ____________ Termination Date: ______________
Class Change Date: __________
Disability Income Amount: _________________________
☐ Original Group ☐ Special Enrollee
☐ New Employee ☐ Late Enrollee

Employee Signature **Date**

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.

WAIVER OF GROUP COVERAGE

(MUST BE COMPLETED IF ANY COVERAGE IS DECLINED OR REFUSED BY AN ELIGIBLE EMPLOYEE)

EMPLOYEE NAME ______________________________ SOCIAL SECURITY #___________________ EMPLOYER NAME ______________________________

- ☐ I WAIVE TOTAL COVERAGE FOR MYSELF (AND DEPENDENTS, IF ANY)
- ☐ I WAIVE HEALTH PLAN COVERAGE FOR MYSELF (AND DEPENDENTS, IF ANY)
- ☐ I WAIVE HEALTH PLAN COVERAGE FOR MY SPOUSE ONLY
- ☐ I WAIVE HEALTH PLAN COVERAGE FOR MY CHILDREN ONLY

REASON FOR DECLINING COVERAGE (CHECK ONE):

- ☐ COVERED BY SPOUSES COVERAGE
- ☐ COVERED BY CHAMPUS OR CHAMPVA
- ☐ COVERED BY HMO
- ☐ OTHER (EXPLAIN) ________________________________
  ____

THIS IS TO ACKNOWLEDGE THAT THE AVAILABLE COVERAGES HAVE BEEN EXPLAINED TO ME BY MY EMPLOYER. I HAVE BEEN GIVEN THE OPPORTUNITY TO APPLY FOR THE AVAILABLE COVERAGES AND HAVE ELECTED NOT TO ENROLL MYSELF AND/OR MY DEPENDENTS, IF ANY.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if employer contributions towards your or your dependent's other coverage terminate), provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself or your dependents, provided that you request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption. To request such special enrollment, please contact the Enrollment Department, (801) 263-8000 x104 or (800) 748-5340 x104.

X____ ______________________________

EMPLOYEE SIGNATURE DATE

WA EE App 1 (1/07)