AAI, Inc.
GROUP ENROLLMENT FORM / CHANGE FORM

☐ NEW ENROLLEE ☐ CHANGE IN CURRENT STATUS ☐ ANNUAL ENROLLMENT
☐ SPECIAL ENROLLMENT: SPECIAL EVENT_____ DATE OF SPECIAL EVENT_____

THIS AREA TO BE COMPLETED BY EMPLOYER

GROUP #	LOCATION #
110171	
DATE OF EMP	COV EFF. DATE

YOUR NAME (Please Print) _____
Last First Middle Initial

ADDRESS _____
Street / Apt #

ADDRESS _____
City State Zip Code

Phone- Home Work e-mail

☐ MALE ☐ FEMALE
GENDER

_____ / _____ / _____
Mo. Day Year
DATE OF BIRTH

___ ___ ___ / ___ ___ / ___ ___ ___ ___
SOCIAL SECURITY NUMBER

☐ SINGLE ☐ WIDOWED
☐ MARRIED ☐ DIVORCED

COVERAGE (Check only those that apply)

MEDICAL COVERAGE: ☐ SINGLE ☐ EMP + SPOUSE ☐ EMP + CHILD(REN) ☐ FAMILY

DEPENDENT INFORMATION (Complete if you elected family Coverage)

DEPENDENT	M	F	FIRST	MIDDLE INT.	LAST	SSN#	DATE OF BIRTH MONTH DAY YEAR
SPOUSE	☐	☐					
CHILD	☐	☐					
CHILD	☐	☐					
CHILD	☐	☐					
CHILD	☐	☐					

IF YOUR SPOUSE OR CHILDREN HAVE A LAST NAME DIFFERENT FROM YOURS, PLEASE PROVIDE A MARRIAGE LICENSE AND/OR BIRTH CERTIFICATE.
IF YOUR DEPENDENT CHILD IS 26 OR OLDER, PLEASE PROVIDE DISABILITY VERIFICATION. DATE OF MARRIAGE: _____ / _____ / _____

OTHER INSURANCE

ARE YOU OR ANY OF YOUR DEPENDENTS COVERED BY ANOTHER GROUP MEDICAL PLAN? ☐ YES ☐ NO
IF YES, EFFECTIVE DATE OF COVERAGE _____ / _____ / _____
NAME OF PRIMARY INSURED / POLICY HOLDER _____ DATE OF BIRTH OF POLICY HOLDER _____ / _____ / _____
NAME OF COVERED DEPENDENT(S) _____
ID NUMBER_____ NAME OF INSURANCE CARRIER OR TPA_____
ADDRESS _____ PHONE _____
NAME OF OTHER EMPLOYER PROVIDING COVERAGE _____ IS MEDICARE/MEDICAID APPLICABLE? ☐ YES ☐ NO
IS YOUR SPOUSE EMPLOYED? ☐ YES ☐ NO IF YES, IS SPOUSE ELIGIBLE FOR INSURANCE THROUGH EMPLOYER NOW OR IN THE FUTURE? ☐ YES ☐ NO
PROVIDE DETAILS _____
IS THERE A DIVORCE DECREE OR COURT ORDER REQUIRING YOU TO BE FINANCIALLY RESPONSIBLE FOR MEDICAL COVERAGE FOR DEPENDENT CHILDREN?
☐ YES ☐ NO IF YES, PROVIDE COPY WHO HAS PRIMARY CUSTODY OF COVERED CHILDREN? ☐ MOTHER ☐ FATHER

BENEFIT WAIVER STATEMENT

I THE UNDERSIGNED CERTIFY THAT I HAVE BEEN GIVEN AN OPPORTUNITY TO APPLY FOR THE GROUP BENEFIT PLAN OFFERED BY THE COMPANY AND AFTER CAREFUL CONSIDERATION HAVE DECIDED TO DECLINE TO ENROLL IN THE COVERAGE HEREAFTER INDICATED.

DECLINE MEDICAL COVERAGE FOR:
☐ MYSELF AND ALL DEPENDENTS ☐ MY DEPENDENTS (SPOUSE AND CHILD(REN)
☐ MY SPOUSE ONLY ☐ MY CHILD(REN) ONLY

ARE YOU DECLINING DUE TO COVERAGE IN ANOTHER PLAN? ☐ YES ☐ NO (IF BLANK, THE PLAN WILL ASSUME "NO")
IF YES, IS THIS OTHER COVERAGE COBRA? ☐ YES ☐ NO

☐ OTHER (PLEASE EXPLAIN) _____

IMPORTANT NOTICE: If you refuse coverage for yourself, you automatically refuse coverage for any dependents. 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 provided that you request enrollment within 30 days after your other coverage ends. Also, you must indicate the reason for declining enrollment to later be eligible under the special enrollment rules. 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 and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. I have received and read a summary of the plan description, and any amendments regarding the impact of HIPAA. I certify that the above information is true and accurate.

SIGNATURE OF EMPLOYEE **to DECLINE**_____ DATE SIGNED _____

DATE AND SIGN ENROLLMENT FORM ELECTIONS

SIGNATURE OF EMPLOYEE **to ELECT**_____ DATE SIGNED _____
If contributions are required for any of the above coverage, I authorize the Company to deduct from my earnings the applicable contribution(s) for the coverage hereafter listed (if none, please indicate.)