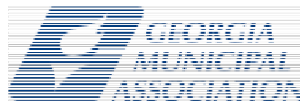

FAX TO: 678-651-1036 (Preferred)

MAIL TO: GMEBS Life & Health
Enrollment Processing
PO Box 105377
Atlanta, Georgia 30348

Effective Date:

PLEASE USE BLACK INK

Benefit Enrollment Form

Group Name: Stonecrest

Group Number:

SubGroup:

Coverage applied for:
☐ PPO 90/70 ______
☐ PPO 80/60 ______
☐ Dental Only
☐ POS 80/60 $5,000
☐ POS 90/70 $1,000
☐ Vision Only
☐ POS ______
☐ HMO ______%
☐ Open Enrollment
☐ Special Enrollment
☐ ACA Enrollment

Employment Status:
☒ Active
☐ Part-Time to Full-time
Part-time Date of Hire
Full-time Date of Hire

Notice for HMO enrollees- Benefits are provided ONLY when covered services are provided by an HMO participating provider.

Note: You may obtain a Summary of Benefits and Coverage (SBC), which summarizes important information about the health plan(s) offered by your Employer. The SBC will help you understand the plan(s) and compare your options (if more than one plan option is offered by your Employer).

The SBC is available on the web at: www.gmanet.com/lhforms. A paper copy is also available, free of charge, by calling 1-888-488-4462.

Special Enrollment - Documentation supporting eligibility to enroll outside of initial or open enrollment is required.

Employee

Social Security Number:

Date of Birth:

Marital Status:
☐ Single
☐ Married
☐ Divorced
☐ Widowed

Date of Hire:

Last Name:

First Name:

MI:

Home Address:

City:

State:

Zip Code:

Home Phone:

Sex: ☐ Male ☐ Female

Are you applying for dental? ☐ Yes ☐ No

Are you applying for vision? ☐ Yes ☐ No

Coverage Refused:
☐ Medical ☐ Dental ☐ Vision

Spouse

Spouse Last Name:

Spouse First Name:

MI:

Social Security Number:

Date of Birth:

Sex:
☐ Female
☐ Male

Coverage Applied For:
Medical ☐ Yes ☐ No
Dental ☐ Yes ☐ No
Vision ☐ Yes ☐ No

☐ Attach documentation supporting eligibility

Please complete page 2 for additional dependents.

GMEBSLH.BEF01 (02/2019)

Group Name: Stonecrest

Social Security Number:

Last Name: First Name: MI:

Please complete the above information

Additional Dependents

Child

Last Name: First Name: MI:

Social Security Number: Date of Birth: Sex: Female Male

Handicapped? Yes No

Coverage Applied For: Medical Yes No; Dental Yes No; Vision Yes No

Attach documentation supporting eligibility

Child

Last Name: First Name: MI:

Social Security Number: Date of Birth: Sex: Female Male

Handicapped? Yes No

Coverage Applied For: Medical Yes No; Dental Yes No; Vision Yes No

Attach documentation supporting eligibility

Child

Last Name: First Name: MI:

Social Security Number: Date of Birth: Sex: Female Male

Handicapped? Yes No

Coverage Applied For: Medical Yes No; Dental Yes No; Vision Yes No

Attach documentation supporting eligibility

Child

Last Name: First Name: MI:

Social Security Number: Date of Birth: Sex: Female Male

Handicapped? Yes No

Coverage Applied For: Medical Yes No; Dental Yes No; Vision Yes No

Attach documentation supporting eligibility

Group Name: Stonecrest

Social Security Number:

Last Name: | First Name: | MI:

Please complete the above information

Other Insurance

Please complete this section if you or any dependents will have other medical or dental insurance, including Medicare, after coverage begins.

Name of Insured:	Effective Date:	Policy #	Group #	Contract Type: ☐ Self ☐ Spouse ☐ Family

Insurance Company:	Address:	City:	State:	Zip:

Self - Are you eligible for Medicare?: ☐ Part A / Effective Date ☐ Part B / Effective Date

Is your spouse eligible for Medicare?: ☐ Part A / Effective Date ☐ Part B / Effective Date

MEDICARE HIC#: Is Medicare coverage related to end stage renal disease? ☐ Yes ☐ No

SAVE AFFIDAVIT. This application for enrollment in the health plan will not be complete until the employee requesting benefits submits to GMEBS a properly completed affidavit confirming the employee's United States citizenship or otherwise lawful presence in the United States. To confirm an employee's eligibility for benefits, GMEBS will verify the employee's alien registration number (if applicable) through the federal Systematic Alien Verification of Entitlement (SAVE) program or a successor program designated by the United States Department of Homeland Security. Until this verification is made, a properly completed affidavit may be presumed to be proof of the employee's lawful presence for the purpose of receiving health benefits. In the event that SAVE is unable to verify an employee's eligibility for health benefits, the employee's health benefits will be terminated.

Documentation. Attach a copy of marriage certificate if enrolling a spouse or stepchild. Attach a copy of birth certificate if enrolling any child. Attach proof of loss of other coverage if requesting special enrollment. Additional documentation may be required.

Employee Affirmation: I affirm that the information provided in this form and the attached documents are accurate.

EMPLOYEE SIGNATURE: ____________________ Date: __________

Employer Affirmation: I affirm that the individual listed above meets the requirements for eligibility that are stated in the Employer's applicable Declaration Pages.

EMPLOYER SIGNATURE: Steven McClure Date: __________