PRIMARY PARTICIPANT ENROLLMENT FORM

www.gbs-tpa.com

PRIMARY PARTICIPANT INFORMATION

Big Tree - Group # 90800

☐ Male
Name: _____ ☐ Female Date of Birth: _____ ❑ Single ❑ Married ❑ Divorced

Home Address: _____ City:_____State:_____ Zip Code: _____

Social Security Number: _____ Daytime Phone #: _____

E-mail Address: _____

***IMPORTANT DISCLOSURE AND COVERAGE INFORMATION ***

1. You must be a US Citizen or Legal Alien residing in the USA to be eligible for all coverage's under this Plan.
2. Enrolling in this plan requires a 12 month commitment. No early terminations allowed.

Benefit Enrollment Coverage Class	Medical	Dental	Vision
Employee Only:	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Employee/Children:	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Employee/Spouse:	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Employee/Family:	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

ENROLLING DEPENDENT INFORMATION (Only list dependents you are enrolling on this Plan)

Dep.#	Relation to Employee	First Name, M. I. Last Name (if different*),	Gender (M / F)	Social Security Number	Date of Birth
1					
2					
3					
4					
5					

*Dependents with different last names from the employee will require additional proof (Marriage License, Proof of Guardianship, Divorce Decree, etc.) in order to become active under this plan.

PLEASE READ CAREFULLY

ELECTRONIC WAIVER:

GBS provides 24 hours a day, seven days a week access to your online employee benefits web portal located at: www.gbs-tpa.com . By signing this form I understand that I have electronic access to a wide variety of Plan documentation including the Summary Benefit of Coverage (SBC) at any time.

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I REPRESENT: (1) I am an employee of the participating employer and the persons for whom I am requesting coverage are US Citizens or Legal Aliens residing in the USA; (2) the statements and answers to the questions on this Enrollment/Refusal Form made by me are true and complete to the best of my knowledge; (3) I understand that the statements and answers to questions on the Enrollment/Refusal Form made by me and any subsequent information I provide are the basis for my coverage under my employer's Plan and coverage will not be effective until I am notified of my effective date; (4) if any controversy or claim is made arising out of or relating to a claim for benefits payable by the self-funded Plan it shall be settled by arbitration in accordance with the provisions of the Plan.

I AUTHORIZE: (1) any physician, medical practitioner, hospital, clinic, pharmacy benefit managers, Veteran's Administration, or other medical-related facility, Insurance agent, administrator, Insurance Company, reinsurer, consumer reporting agency, telephone interview Company, or my employer to release any information pertaining to my employment or to the health of myself or my dependents, including physical or mental disorders or the use of drugs and alcohol, to Group Benefit Services; (2) Group Benefit Services to release such information to any Insurance agent, Insurance Company, reinsurer, managed care organization, telephone interview Company, other Insurance support organization, or my employer; (3) my employer to deduct contributions from my earnings to be applied to the cost of this Plan; and (4) that benefits under this Plan be paid directly to any managed care provider utilized by me or my family.

I agree this authorization will be valid for two years from the date this form is signed and that a photocopy of this authorization is as valid as the original for my dependent(s) and/or for me.

Employee Signature: X_____ **Date Signed:** _____

(PLEASE DO NOT PRINT)

This authorization form will be valid for two years from the date this form is signed by me and that a photocopy of this executed authorization is as valid as the original for my dependent(s) and/or for me.