



Section A: Employer Information

LAKE-SUMTER MEDICAL SOCIETY

1. Name of Employer & Group Name: - LSMS					2. Group #: 64715					
3. Effective Date of Coverage:			4. Location Number:		5. Date of Hire:			6. Job Title:		

Section B: Employee Information (Note: If additional space is needed please print on separate sheet, sign and date.)

7. Last Name:										8. First Name:										9. M.I.	
10. Social Security Number:										11. Date of Birth:						12. Sex:					
13. Mailing Address:										14. Apt. #:		15. City:				16. State:		17. Zip:			
18. County:			19. Home Phone with Area Code:				20. Marital Status:														
						<input type="checkbox"/> Single		<input type="checkbox"/> Married		<input type="checkbox"/> Divorced		<input type="checkbox"/> Widowed		<input type="checkbox"/> Legally Separated							

Section C: Coverage Level and Plan Information

21. Employee Health Coverage Level: <i>Check box that applies</i>			22. EMPLOYEE PLAN CHOICES:					**If selected by your employer, Basic Family Life Insurance Coverage is provided, therefore please complete beneficiary information below, sign and date.						
<input type="checkbox"/> Employee Only <input type="checkbox"/> Family			<input type="checkbox"/> Plan "A" <input type="checkbox"/> Plan "B" <input type="checkbox"/> Plan "C" <input type="checkbox"/> Rewards <input type="checkbox"/> HSA <small>Employee</small>											
23. Physician Health Coverage Level: <i>Check box that applies</i>			24. PHYSICIAN PLAN CHOICES:											
<input type="checkbox"/> Employee Only <input type="checkbox"/> Family			<input type="checkbox"/> Plan "D" <input type="checkbox"/> Plan "E" <input type="checkbox"/> Plan "F" (HSA)											
25. <input type="checkbox"/> I am refusing all Health Coverage at this time. I understand that if I decide to apply later coverage may not be available until any qualified special enrollment period.											Signature: _____		Date: _____	

Section D: Health Insurance Dependent Information (Attach separate sheet if additional space is needed for dependent information, sign & date.)

26. Last Name: (if different than employee) First Name, M.I.	Social Security Number	Date of Birth	Relation to You								
			(S) Spouse	(C) Child	(O)* Other	M/F Sex	Check if Disabled	You Support	Lives With You	Is a Student	
								<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
								<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
								<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
								<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

* If you indicated "O" in "Relation to You" above for any dependents, please explain here:

Section E: Other Health Insurance Information *This section must be completed for claims processing.*

27. In addition to this policy, do you or your dependents have any other insurance coverage (including BCBSF plans) that will be in effect after this coverage begins? Yes No BCBSF Contract # _____ Medicare # _____ Pharmacy/Medicare D # _____

****Beneficiary Information for Basic Family Life Insurance Coverage**

28. Name (last name, first, middle initial):	Relation To You:	Benefit %
29. If the Beneficiary(ies) Named Above are Not Living, Then Pay:		

Section F: Acceptance of Health Coverage and Life Insurance Coverage

30. **Request for Signature and Certification:** I have read and understand the "Limitations and Exclusions" on the reverse side of this enrollment form. I certify that all statements are true to the best of my knowledge and belief and I understand that a copy of this form will be made available to me at my request. I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective. I understand that my payroll deduction amount will change if my coverage or costs change. I agree to be bound to the terms and/conditions for the master policy.

31. Signature:	32. Date:

Limitations and Exclusions for Life Insurance

DELAYED EFFECTIVE DATE:

Employee: Insurance will be delayed for employees not in active employment until the first of the month, coincident with or next, following the date they return to work. Regularly scheduled vacation time is considered active employment. **Dependents:** Coverage for totally disabled dependents will be delayed until the first of the month, coincident with or next, following the date the individual is no longer disabled. This delay does not apply to newborn children while dependent insurance is in effect. **Totally disabled"** means that, as a result of injury, a sickness or a disorder, your dependent is confined in a hospital or similar institution; is unable to perform two or more activities of daily living (ADLs) because of a physical or mental incapacity resulting from an injury or a sickness; is cognitively impaired; or has a life threatening condition.

EXCLUSION FOR SUICIDE:

Where the cause of death is suicide:

- 1. No benefits will be payable for a loss occurring within 24 months after the individual's initial effective date; and**
- 2. No increased or additional insurance will be payable for a loss occurring within 24-months after the day such increased or additional insurance is effective.**

This Suicide Exclusion does not apply to Washington residents.

AD&D BENEFIT EXCLUSIONS

AD&D Benefits would not be paid for losses caused by, contributed to by, or resulting from:

- Disease of the body or diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders;**
- Suicide, self-destruction while sane, or self-inflicted injury;**
- War, declared or undeclared, or any act of war;**
- Active participation in a riot;**
- Attempt to commit or commission of a crime;**
- The voluntary use of any prescription or non-prescription drug, poison, fume or any other chemical substance unless used according to the prescription or direction of the individual's doctor. This exclusion does not apply to the individual if the chemical substance is ethanol; or**
- Intoxication. ("Intoxicated" means that the individual's blood alcohol level equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the accident occurred.)**

Conditions, Limitations, and Exclusions for Health Insurance shall be provided in writing to the employee and may change, with advanced notice to the employee.

RETAIN A COPY OF THIS FORM FOR YOUR RECORDS AND SEND A COPY TO YOUR EMPLOYER

Instructions for Completing Enrollment Application Lake-Sumter Medical Society Health Plan

INSTRUCTIONS: Please PRINT in CAPITAL letters using black or blue ink.

Section A Employer Information

- Item 1. Group Name: Please list the name of your employer's office followed by "MCMS".
- Item 2. Group #: No response needed.
- Item 3. Effective Date of Coverage: This will be completed by the Office Manager or Benefit Administrator.
- Item 4. Location Number: This will be completed by Officer Manager or Benefit Administrator.
- Item 5. Date of Hire: This will be completed by the Office Manager.
- Item 6. Job Title: Please print your Job Title.

Section B Employee Information

Items 7 to 20: Please complete each.

Section C Coverage Level and Plan Information

- Item 21. (Employee): If you are an Employee, mark either "Employee" or "Family" Coverage.
- Item 22. (Employee): Select the Plan in which you wish to enroll; Plan "A", Plan "B" or Plan "C".
Employee Rewards or H S A.
- Item 23. (Physician): *If you are a Physician, mark either "Employee" or "Family" Coverage.
- Item 24. (Physician): *Select the Plan in which you wish to enroll; Plan "D", Plan "E", Plan "F".
- Item 25. Refusal of Coverage: If you DO NOT wish to be covered under the Group Health Plan, indicate by placing a check mark, sign & date. Note: The MCMS DOES NOT have "open enrollment" and, if you refuse health coverage now, you should complete a "Special Enrollment Rights" form. If you or your dependents have a "Qualifying Event", this will enable you to obtain coverage in the future through the MCMS for you and/or your dependents.

Section D Health Insurance Dependent Information

- Item 26. Dependent Information: Complete the names of your Spouse and Children in the first section. Also include Social Security Number, Date of Birth. Identify if the dependent is a spouse or child and indicate the sex of each dependent. Indicate if the dependent is disabled, if you support, if the dependent lives with you, and if the dependent is a student.

Section E Other Health Insurance Information

- Item 27. Other Health Insurance: Complete this by answering if you or your dependents will have coverage in addition to this BCBS policy.

Beneficiary Information for Basic Family Life and AD&D coverage Items 28 and 29: If your employer provides Basic Family Life and AD&D coverage for its employees, list your primary beneficiaries under Item 28 and your secondary beneficiaries under Item 29.

Section F Acceptance of Health Coverage & Life Insurance Coverage

- Items 31 & 32: Sign and date.

Return completed form to the Office Manager and Keep a copy for your files.