National Academy of Sciences Enrollment Application (Medical and Dental)

PLEASE READ INSTRUCTIONS BELOW. PLEASE PRINT CLEARLY.

Section 1

ASSOCIATE INFORMATION						
LAST NAME Smith	FIRST NAME Jasmine	MI M	SEX ☐ Male ■ Female	DATE OF BIRTH 01/01/1988	SOCIAL SECURITY NUMBER 123-45-6789	MARITAL STATUS ☐ Single ■ Married
HOME ADDRESS 1111 Main Street	CITY Washington	STATE DC	ZIP CODE 20001	HOME PHONE NUMBER (202) 332-3000		
SPONSOR NAME National Academy of Sciences	WORK PHONE NUMBER (202) 334-4000					

Section 2

MEDICAL and Dental COVERAGE

☐ **Associate Only**

■ **Associate Plus Family**

☐ I decline coverage

Reason:
☐ Covered under another plan.
☐ Other: ________________

**Note: If you are declining coverage for yourself or your dependants, because of coverage under other health coverage, you are required to complete this section. Your failure to do so may cause you or your dependents to be considered late enrollees if you enroll in this plan at a later date.*

Section 3

COVERAGE INFORMATION					
(A) Add (T) Term (C) Chg	Last Name First Name MI	Date of Birth (Mo/Day/Yr)	Sex	Social Security Number	Handicapped?
A	Associate Jasmine M. Smith	01/01/1988	☐ M ■ F	123-45-6789	☐ Y ■ N
A	Spouse Jorge F. Smith	07/16/1980	■ M ☐ F	234-56-7890	☐ Y ■ N
A	Child-1 Bianca M. Smith	03/30/2005	☐ M ■ F	345-67-8901	☐ Y ■ N
	Child-2		☐ M ☐ F		☐ Y ☐ N
	Child-3		☐ M ☐ F		☐ Y ☐ N
	Child-4		☐ M ☐ F		☐ Y ☐ N

Section 4

OTHER INSURANCE

On the day your coverage begins, will any family members, including those not listed above, be covered by any other health benefit plan, health or dental insurance, Medicare or Medicaid? ■ Y ☐ N

Is another person legally responsible for coverage for your children? ☐ Y ■ N

If you answered yes to either of the questions above, please complete the following:

Person's Name with Other Health Plan			Social Security Number
Jorge F. Smith			234-56-7890

Date of Birth	Sex	Other Company's Name and Phone Number
07/16/1980	Male	Aetna 888-333-4444

Other Company's Policy Number and Effective Date
XYZ12345 Effective through January 31, 2015

Medicare Number	Part A Effective Date	Part B Effective Date

CareFirst

Section 5

AUTHORIZATION

On behalf of myself and anyone enrolled on or added to this form ("Us"), I authorize the use of a Social Security Number for purpose of identification.

I understand and agree that any omissions or incorrect statements made on this application may invalidate my and/or my dependent's coverage.

I further understand that coverage will become effective only on the date specified by the Insurer or Plan Administrator after it has been approved by the Insurer or Plan Administrator and after the full premium has been paid.

By signing this form, I hereby certify that all the information provided is true and correct.

NOTICE OF ENROLLMENT RIGHTS

I understand that if I and/or my dependents, if any, waive coverage and desire to participate in the plan at a later date, coverage may be subject to treatment as a late enrollee. I further understand that if I decline enrollment for myself or dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 30 days after such marriage, birth, adoption, or placement for adoption.

X Signature Jasmine Smith **Date** 2/1/16

Section 6

TO BE COMPLETED BY THE NATIONAL ACADEMY OF SCIENCES

DATE OF HIRE	DATE SUBMITTED	HEALTH/CHANGE EFF. DATE	POLICY NUMBER	GRP/SUBGRP/BNFT GRP	PLAN VARIATION/SUB	REPORTING CODE/BRANCH	ADMINISTRATOR SIGNATURE

Enrollment Application and Change Form
Instructions

Use this form and follow the instructions for each section below. Please make sure that all applicable fields are completely and accurately filled out.

Check appropriate box to indicate if you are enrolling for the first time or making a change.

SECTION 1 Complete all information.

SECTION 2 Check the coverage tier you would like and who should be covered

SECTION 3 Fill in the appropriate action code for completing this form:

A = To add a dependent to your benefit plan.
T = To terminate yourself or a dependent's coverage.
C = To change information about yourself or a dependent.

Print your full name and the names of your covered dependents, if any. Check which type of coverage you will be enrolling yourself and your dependents in. Provide the date of birth, sex and social security number for each dependent and check the appropriate boxes indicating if a dependent is handicapped. (If you have more than 5 dependents, please attach an additional enrollment form.)

SECTION 4 This section must be completed for all new enrollments or coverage changes.

SECTION 5 The Associate must sign and date this form in order for it to be processed.

SECTION 6 This section is to be completed by the National Academy of Sciences's benefit representative.