PRAIRIE STATES

Enrollment Application & Participant Agreement

Type of Change:	✕ New Enrollment	☐ Cancel Coverage	☐ Address	☐ Transfer	☐ Add/Drop Dependent(s)
Medical Coverage Desired:	☐ Single	☐ Family	Network Elected:	☐ Health EOS	☐ America's PPO
Hire Date:			Effective Date:		

First Name:	MI:	Last Name:	Social Security Number:
Home Address:	City	State:	Zip Code:
Gender: ☐ Male ☐ Female	Date of Birth:	Marital Status: ☐ Single ☐ Married ☐ Divorced	
Email Address:	Home Phone Number:	Cell Phone Number:	

DEPENDENT INFORMATION INCLUDING OTHER COVERAGE – Please choose either "yes" or "no." Do not leave blank. (Complete only if covering dependents under this Plan)

Last Name (if different from employee)	M.I.	First Name	Gender	Date of Birth	Relationship	SSN is required for all dependents enrolled. Social Security Number	Coverage Under Another Plan? Yes	No
Spouse								
Dependent 1								
Dependent 2								
Dependent 3								
Dependent 4								

AUTHORIZATION

On behalf of myself and anyone enrolled on or added to this Enrollment Application, I authorize any healthcare professional or entity to give any and all records or information pertaining to medical services rendered to Us for any administrative purpose, and I authorize on behalf of Us the use of a social security number or other employee identification number for identification purposes.

Employee Signature: ______________________ Date: ______________________

Complete only if you are NOT enrolling in health insurance for July 1, 2024. WAIVER OF GROUP INSURANCE

I hereby acknowledge that I have been given the opportunity to apply for group insurance as offered by my employer or after being enrolled in the health insurance coverage, I have decided:

☐ I waive (do not want) coverage for: *or* ☐ I cancel coverage for: ☐ Myself ☐ My spouse ☐ My children

Reason for Refusing / Canceling Coverage: ☐ Spouse's Plan ☐ Other

If you are declining enrollment or canceling coverage for yourself or your dependents (including your spouse) because of other health insurance coverage, and, if in the future you lose such coverage under certain circumstances listed in the Plan Document, you will be able to enroll yourself or dependents in this Plan within 31 days of losing such coverage. Not all loss of coverage gives you this special right. For example, if you or your spouse drops the other coverage because you think it is too expensive, this does not give you special enrollment rights.

Employee Signature: ______________________ Date: ______________________