EXCEL HEALTH PLAN
ENROLLMENT FORM

SECTION 1 EMPLOYEE INFORMATION

EMPLOYER ______ GROUP # ______ LOCATION ______ DATE OF HIRE ______

FIRST NAME ______ M.I. ______ LAST NAME ______ DATE OF BIRTH ______

ADDRESS ______ CITY ______ STATE ______ ZIP ______ SSN ______

PHONE NUMBER ______ EMAIL ADDRESS ______ GENDER ☐ MALE ☐ FEMALE

SECTION 2 ELECT MEDICAL COVERAGE

I understand that I will not be allowed to enroll again until my eligibility due to a qualifying event as defined by IRS Section 125 or the next open enrollment period.

☐ EMPLOYEE ONLY ☐ EMPLOYEE + 1 ☐ EMPLOYEE + 2 ☐ EMPLOYEE + 3 OR MORE

SECTION 3 DEPENDENT INFORMATION

	DEPENDENT NAME	RELATIONSHIP	GENDER	DATE OF BIRTH	SOCIAL SECURITY NUMBER
1					
2					
3					
4					
5					
6					

SECTION 4 ENROLL OR WAIVE/DECLINE COVERAGE

WRITE YOUR INITIALS BELOW TO ACKNOWLEDGE THE FOLLOWING STATEMENTS:

______ I acknowledge that as of January 1, 2014, the Affordable Care Act requires me, by law, to cover myself and my dependents in a health insurance plan that meets minimum essential coverage requirements (Title 1, Sec 1501).

______ I acknowledge that I have been made aware of health insurance options offered by my employer that meet the minimum essential coverage requirements (Title 1, Sec 1512, 1513).

______ I acknowledge that the Minimum Essential Coverage (MEC) benefit is NOT a major medical plan and that it only covers select preventive services.

SELECT AND SIGN ONE OF THE OPTIONS BELOW.

☐ **I AM ENROLLING IN COVERAGE.** SIGNATURE ______ DATE ______

☐ **I AM DECLINING COVERAGE.** SIGNATURE ______ DATE ______

I AM WAIVING COVERAGE OFFERED TO ME DUE TO: ☐ OTHER COVERAGE *(Indicate type of other coverage below)* ☐ COST

If other coverage, TYPE OF OTHER COVERAGE: ☐ INDIVIDUAL ☐ FEDERAL EXCHANGE ☐ MEDICARE ☐ MEDICAID