


**HOW TO COMPLETE YOUR ENROLLMENT REQUEST**  
Please be sure to complete all information on this card



## Enrollment Request

GE Group Life Assurance Company  
 Attn: Group Eligibility  
 100 Bright Meadow Boulevard, Enfield, CT 06082  
 www.gefinancialbenefits.com

Add     Change     Termination     Correction  
 Date: \_\_\_\_\_ Reason: \_\_\_\_\_

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**Employer Information - to be completed by Employer**

1. Group Account Number	2. Other Group Account Number(s)	3. Class	Network	Billing Group
4. Name of Employer				
5. Employer's Address (Number, Street, City, State, ZIP Code)				

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**Employee Information - to be completed by Employee (This entire section must be complete to avoid processing delays)**

6. Name of Employee (Last, First, M.I.)			7. Social Security Number	
8. Employee's Address (Number, Street, City, State, ZIP Code)			9. Employee's Home Phone No.	
10. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	11. Date of Birth (Mo., Day, Yr.)	12. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married		13. My employment is covered under Union Collective Bargaining <input type="checkbox"/> Yes
14. Hours worked weekly for this employer (Excluding Overtime) <input type="checkbox"/> Active <input type="checkbox"/> Retired		15. Date Employed (Mo., Day, Yr.) <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-time <input type="checkbox"/> Rehire <input type="checkbox"/> Return from Layoff		
16. Basic Earnings \$ _____ Hrs/Wk _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Annually		17. Employee's Occupation (Title)		

NOTE: If you refuse Medical or Dental benefits for yourself, you automatically refuse these benefits for any dependents. If you refuse any benefit now, and later request to add that benefit, your coverage may be limited as outlined in the certificate. Some or all of these benefits may be funded by your employer. Administrative Services and forms provided by GE Group Administrators, Inc. and/or GE Group Life Assurance Company does not imply liability for GE GA and/or GEGLAC for claim payment. See your employer for details. THOSE BENEFITS COMPLETELY PAID FOR BY THE EMPLOYER CANNOT BE REFUSED. All benefits may not be available; check with your plan administrator. Indicate your choice by checking the appropriate boxes.

**Group Benefits Requested - to be completed by Employee**

Life/AD&D <input type="checkbox"/> I Elect <input type="checkbox"/> I Refuse	Dependent Life/AD&D <input type="checkbox"/> I Elect <input type="checkbox"/> I Refuse	Supplemental Life/AD&D <input type="checkbox"/> I Elect <input type="checkbox"/> I Refuse
Dental <input type="checkbox"/> I Elect <input type="checkbox"/> I Refuse	Medical <input type="checkbox"/> I Elect <input type="checkbox"/> I Refuse	Weekly Indemnity <input type="checkbox"/> I Elect <input type="checkbox"/> I Refuse
Dependent Dental <input type="checkbox"/> I Elect <input type="checkbox"/> I Refuse	Dependent Medical <input type="checkbox"/> I Elect <input type="checkbox"/> I Refuse	Long Term Disability <input type="checkbox"/> I Elect <input type="checkbox"/> I Refuse

\*If you have refused Medical or Dental, is it because you have other Group Coverage?  
 Medical  Yes  No      Dental  Yes  No      \*If you have refused Medical or Dental for your dependents, is it because they have other Group Coverage?  
 Medical  Yes  No      Dental  Yes  No

**Please Complete The Following Question If You Are Electing Medical Coverage**

Did you or your dependent have prior medical coverage?  Yes If so,  Single  Family  Dependent(s)  
 Individual Policy  Group Policy  HMO  Other \_\_\_\_\_

Name of Carrier \_\_\_\_\_ Termination date of Coverage \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Reason for Termination \_\_\_\_\_

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**Please complete this entire section if you are selecting Medical and/or Dental Coverage.**

Relationship	Last Name	First Name	M.I.	Date of Birth	Sex	Social Security Number
Employee						/ /
						/ /
						/ /
						/ /

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**Student Verification - Please complete the following if any child listed is a full-time college student.**

Name of Child: \_\_\_\_\_ School Name and Address: \_\_\_\_\_  
 Course of Study: \_\_\_\_\_ Semester: \_\_\_\_\_ Anticipated Date of Graduation (month/year): \_\_\_\_\_

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**Beneficiary Designation - applies ONLY if life insurance is being elected at this time**

22. Primary - Last Name	First Name & Middle Initial	Relationship	Address
23. Contingent - Last Name	First Name & Middle Initial	Relationship	Address

NOTE: You may designate a new beneficiary at any time, subject to the conditions and provisions of the Group Policy.  
 I request benefits under the group coverage issued by GE Group Life Assurance Company and the Group Benefit Plan(s) sponsored by my employer and authorize deductions from my earnings of any required contributions for any such coverage for which I am or may later become eligible. On behalf of myself and any dependents listed on this enrollment request, I apply, or as indicated, decline to apply for those benefit(s) for which I am eligible. I state that the information given as part of my enrollment request is true and correct and that this request is subject to the representations made on the reverse side of this request which I have read and fully understand. I understand and agree that any incorrect statements material to the risk made by me in this enrollment request may invalidate my benefit(s) and result in claim denials and that all statements made by me shall be deemed representations and not warranties.  
 I designate the beneficiary(ies) shown above to receive all sums which may become due on account of my death under this group coverage. I understand that proceeds will be payable in equal shares to those primary beneficiaries who survive me but if no primary beneficiary survives such proceeds will instead be payable in equal shares to those contingent beneficiaries who survive me.  
**To the best of my knowledge** I am an employee working the weekly hours shown above at the employer's regular place of business, and I agree any information shown above including the **refusal section** is correct and my signing below indicates that I understand all information given is subject to verification.  
 I agree that my Employer acts as my agent in all dealings with the Plan(s), and that all notices given to him are binding upon me. I also agree that my participation in the benefit(s) and the authorization and agreements stipulated herein are subject to any future amendments to the Plan(s).  
 I certify that I have read the reverse side of this form.

24. Date

25. Signature

ESG-GL2479 (06/04) Original to GEFA • 1st Copy to Employer • 2nd Copy to Employee/Subscriber

**EMPLOYER INFORMATION SECTION MUST BE COMPLETED BY EMPLOYER**

• Legal Name of Employer.

• Occupation / Title must coincide with those listed on your Application / Insurance Benefit.

**EMPLOYEE SECTION**

• Must be completed by employee to determine your eligibility.

• Children between age 19-25 must be full-time students at an accredited college or university.

• Give beneficiary's complete name, relationship to you and Full address.

• If beneficiary is a married woman, show given name (Mary J. Jones **Not** Mrs. John Jones).

• If you wish to designate any arrangement other than the primary/contingent designation, please send complete instructions to Group Title, GE Group Life Assurance Company; Special forms will be prepared.

NOTE: Employer may not be designated as a beneficiary.

Full signature (must be in ink) of employee is required and must be dated

**Notices Concerning Medical Coverage required by the Health Insurance Portability and Accountability Act of 1996:**

**Pre-Existing Conditions (not applicable to pregnancy).** - The medical plan contains a pre-existing condition limitation that may apply to you and/or your dependents. Any applicable pre-existing condition limitation will be reduced by your prior creditable coverage, if any. You have the right to request a certificate of creditable coverage from your prior health plan and we will assist you in obtaining this certificate, if necessary. For additional information regarding the plan's pre-existing condition limitation, please see your plan administrator. Late entrants to the plan may be subject to an increased pre-existing condition limitation.

**Special Enrollment Rights.** - If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this medical plan, provided you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the date of the marriage, birth, adoption or placement for adoption.



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### Employee Information - to be completed by Employee (This entire section must be complete to avoid processing delays)

6. Name of Employee (Last, First, M.I.)			7. Social Security Number	
8. Employee's Address (Number, Street, City, State, ZIP Code)			9. Employee's Home Phone No.	
10. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	11. Date of Birth (Mo., Day, Yr.)	12. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	13. My employment is covered under Union Collective Bargaining <input type="checkbox"/> Yes	
14. Hours worked weekly for this employer (Excluding Overtime) <input type="checkbox"/> Active <input type="checkbox"/> Retired	15. Date Employed (Mo., Day, Yr.) <input type="checkbox"/> Full-Time ____/____/____ <input type="checkbox"/> Part-time ____/____/____ <input type="checkbox"/> Rehire ____/____/____ <input type="checkbox"/> Return from Layoff ____/____/____			
16. Basic Earnings \$ _____ <input type="checkbox"/> Hourly _____ Hrs/Wk <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Annually	17. Employee's Occupation (Title)			

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*If you have refused Medical or Dental, is it because you have other Group Coverage? Medical <input type="checkbox"/> Yes <input type="checkbox"/> No      Dental <input type="checkbox"/> Yes <input type="checkbox"/> No		**If you have refused Medical or Dental for your dependents, is it because they have other Group Coverage? Medical <input type="checkbox"/> Yes <input type="checkbox"/> No      Dental <input type="checkbox"/> Yes <input type="checkbox"/> No

### Please Complete The Following Question If You Are Electing Medical Coverage

Did you or your dependent have prior medical coverage?  Yes   If so,  Single    Family    Dependent(s)  
 Individual Policy    Group Policy    HMO    Other \_\_\_\_\_

Name of Carrier \_\_\_\_\_ Termination date of Coverage \_\_\_\_/\_\_\_\_/\_\_\_\_  
Reason for Termination \_\_\_\_\_

### Please complete this entire section if you are selecting Medical and/or Dental Coverage.

Relationship	Last Name	First Name	M.I.	Date of Birth	Sex	Social Security Number
Employee						/ /
						/ /
						/ /
						/ /
						/ /

### Student Verification - Please complete the following if any child listed is a full-time college student.

Name of Child: \_\_\_\_\_ School Name and Address: \_\_\_\_\_  
Course of Study: \_\_\_\_\_ Semester: \_\_\_\_\_ Anticipated Date of Graduation (month/year): \_\_\_\_\_

### Beneficiary Designation - applies ONLY if life insurance is being elected at this time

22. Primary - Last Name	First Name & Middle Initial	Relationship	Address
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NOTE: You may designate a new beneficiary at any time, subject to the conditions and provisions of the Group Policy.

I request benefits under the group coverage issued by GE Group Life Assurance Company and the Group Benefit Plan(s) sponsored by my employer and authorize deductions from my earnings of any required contributions for any such coverage for which I am or may later become eligible. On behalf of myself and any dependents listed on this enrollment request, I apply, or as indicated, decline to apply for those benefit(s) for which I am eligible. I state that the information given as part of my enrollment request is true and correct and that this request is subject to the representations made on the reverse side of this request which I have read and fully understand. I understand and agree that any incorrect statements material to the risk made by me in this enrollment request may invalidate my benefit(s) and result in claim denials and that all statements made by me shall be deemed representations and not warranties.

I designate the beneficiary(ies) shown above to receive all sums which may become due on account of my death under this group coverage. I understand that proceeds will be payable in equal shares to those primary beneficiaries who survive me but if no primary beneficiary survives such proceeds will instead be payable in equal shares to those contingent beneficiaries who survive me.

To the best of my knowledge I am an employee working the weekly hours shown above at the employer's regular place of business, and I agree any information shown above including the refusal section is correct and my signing below indicates that I understand all information given is subject to verification.

I agree that my Employer acts as my agent in all dealings with the Plan(s), and that all notices given to him are binding upon me. I also agree that my participation in the benefit(s) and the authorization and agreements stipulated herein are subject to any future amendments to the Plan(s).

I certify that I have read the reverse side of this form.

24. Date      25. Signature

## **WARNING**

### **STATE LAW IN SOME STATES REQUIRES THE FOLLOWING STATEMENT:**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto (in Oregon "may be guilty of insurance fraud") commits a fraudulent insurance act, which (in Oregon "may be subject to prosecution") is a crime and subjects such person to criminal and civil penalties.

### **THIS NOTICE DOES NOT APPLY IN VIRGINIA.**

**IN CALIFORNIA:** "Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

**IN FLORIDA:** "Any person who knowingly and with intent to defraud, or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree."

**IN LOUISIANA:** "Any person knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

**IN NEW JERSEY:** "Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties."

**IN NEW YORK:** "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information containing any fact material thereto, commits a fraudulent insurance act which is a crime and shall be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each violation."

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health coverage.

In Georgia, any person who signs this Enrollment Form acknowledges notification of the following:

1. You are entitled to a list of providers participating in our PPO network. Provider Directories are available by contacting our Group Policyholder Services Department at 800-451-2513 or by viewing our website at [www.gefinancialbenefits.com](http://www.gefinancialbenefits.com).
2. You are entitled to receive treatment from a provider of your choosing. You will receive a higher level of benefits for medical services when choosing a PPO physician or hospital.
3. There are no limited utilization incentive plans for providers of medical services. The provider is not given an incentive or bonus that encourages withholding services or influences referral to specialists.

You will be provided with a Disclosure form after the effective date of your Group Policy. This Disclosure will provide details of the above.