Crescent Limited Medical

Underwritten by: COMPANION LIFE INSURANCE COMPANY

EMPLOYEE APPLICATION FOR INSURANCE (FILL OUT COMPLETELY)

____/____/_____Requested Effective Date ___New Enrollment ___Change ___Termination (see other side)

Employer Name _____

EMPLOYEE INFORMATION

Employee Name _____ **Social Security Number** _____

Home Address

_____

Street City, State Zip Home Telephone e-mail

Sex
- ❑ **Male**
- ❑ **Female**

Circle Marital Status:
1. Single
2. Married
3. Divorced

Date of Birth _____ **Selected Plan**_____

Date of Hire _____ **Number of Hours Worked** _____

Are you covered by Medicare? _____

Circle Desired Coverage:
1. Enrollee Only
2. Enrollee + Spouse
3. Enrollee + Child
4. Enrollee + Family

Life Insurance Beneficiary _____

Beneficiary Relationship _____

DEPENDENT INFORMATION

Dependent Name	Date of Birth	Sex (M/F)	Relationship	Full-Time Student (Yes/No) student verification letter must be attached	Social Security No.
			Spouse	**N/A**	

Use an Additional Form if more space is needed

EMPLOYEE AUTHORIZATION

- ❑ I ELECT TO PARTICIPATE IN THE PLAN AND AUTHORIZE MY EMPLOYER TO MAKE DEDUCTIONS FROM MY PAYCHECK, IF APPLICABLE.
- ❑ I HAVE BEEN GIVEN THE OPPORTUNITY TO PARTICIPATE, BUT I ELECT **NOT TO PARTICIPATE** IN THIS PLAN.

Answer only if your employer has a GROUP MAJOR MEDICAL plan:
- ❑ I am participating in the Group Major Medical Plan
- ❑ I am NOT participating in the Group Major Medical Plan

I understand that the Crescent Limited Medical program is a limited health insurance plan and not a major medical program. I understand that I must be employed at the employer named above and continually meet all insurance company eligibility requirements to remain covered by the Plan and at my age 70 all insurance under the plan expires. I have read any Fraud notice applicable to my state of residence on the reverse side of this application. See fraud notices on the reverse.

_____ _____

Employee Signature Date

MME 2070Crescent

CRESCENT
MEDICAL BRIDGE PLANS
ASSET PROTECTION

Employee Name: _____

For Termination: **To Be Completed by the Employer Only: Below are the qualifications for COBRA continuation**
Please check only one item and then complete the needed information for that specific event.
18 month events
↑___ Any voluntary or involuntary termination other than for gross misconduct- Date: _____
↑___ Reduction in hours (including strikes, leave of absence, and military leave (FMLA is not a COBRA event) - Date: _____
↑___ Coverage dropped as a result of an increase in the employee's contribution - Date: _____

36 month events (For covered spouses and dependents)
↑___ Employee's death - Date: _____
↑___ Employee's entitlement to Medicare - Date:_____
↑___ Divorce or legal separation from a covered employee - Date: _____
↑___ Dependent ceasing to be a covered dependent under plan definitions - Dependent: _____

FRAUD WARNING NOTICES: (If you live in a state where one of the fraud warning notices apply, please review the notice that applies to your state.)

Arkansas/Louisiana	Any person who 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.
Colorado	It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a certificate holder or claimant for the purpose of defrauding or attempting to defraud the policy or certificate holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department regulatory agencies.
DC	It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
Florida	Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
Kentucky/Ohio	I understand that any person who, with intent to defraud, or knowing that he or she is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement is guilty of insurance fraud.
Maine	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefit.
New Mexico/ Pennsylvania	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 commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
Tennessee	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.