PRAIRIE STATES

OMNI GLASS & PAINT

Enrollment Application & Participant Agreement

Medical Coverage Desired: ☐ Single ☐ Family				
Department: ☐ 100-99 Admin	☐ 400-10 Paint Admin	☐ 400-20 Glass Admin	☐ 400-40 OEM Admin	
☐ 400-50 Residential Admin	☐ 400-60 Temp Admin	☐ 400-99 Safety	☐ 500-20 Glass Shop	
☐ 550-20 Fab	☐ 580-20 Glass Field	☐ 600-10 Paint Shop	☐ 650-10 Paint Field	
☐ 590-50 Residential Field	☐ 690-40 OEM	☐ 690-60 Temp		
Hire Date:	Effective Date:			
Type of Change: ☐ New Enrollment ☐ Cancel Coverage ☐ Transfer ☐ Add/Drop Dependent(s)				

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

DEPENDENT INFORMATION INCLUDING OTHER COVERAGE – Please choose either "yes" or "no." Do not leave blank.

Last Name	First Name	MI	Gender	Date of Birth	Social Security Number	Please answer for you, your spouse, and for each dependent whether they have coverage under any other Medical Health Plan or policy including Medicare or Medicaid. If yes, please name plan and indicate if Plan is Primary or Secondary.
Employee						☐ No ☐ Yes If yes, ☐ Primary ☐ Secondary Name of Plan:
Spouse						☐ No ☐ Yes If yes, ☐ Primary ☐ Secondary Name of Plan:
Dependent 1						☐ No ☐ Yes If yes, ☐ Primary ☐ Secondary Name of Plan:
Dependent 2						☐ No ☐ Yes If yes, ☐ Primary ☐ Secondary Name of Plan:
Dependent 3						☐ No ☐ Yes If yes, ☐ Primary ☐ Secondary Name of Plan:

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: _____

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: _____