Employee Benefit Enrollment Form

TRISTAR Benefit Administrators / PO Box 65887 / West Des Moines, IA 50265

Group Number	Location	Employee Classification	Coverage Effective Date

1. Employee Information

Complete ALL sections

Last Name First Name Middle Initial		Date of Birth Month Day Yr	Sex: Male ☐ Female ☐
Mailing Address		Social Security Number	
City State Zip		Marital Status Married ☐ Unmarried ☐	Date Employed Month Date YR
Employer Name	Job Title	Home Telephone No. ( )	

2. Complete this section to indicate the persons to be covered and the desired coverage

Health Plan	Myself ☐	Spouse ☐	Child(ren)☐	Decline*☐
	*If declining, are you enrolled in another health plan? Yes ☐ No ☐			
Dental Plan (if applicable)	Myself ☐	Spouse ☐	Child(ren)☐	Decline*☐
Other Plan (if applicable)	Myself ☐	Spouse ☐	Child(ren)☐	Decline*☐

If you are declining enrollment for yourself or your dependents because of other health coverage, you may in the future be able to enroll yourself or your dependents, provided that 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 marriage, birth, adoption or placement for adoption.

Dependent	Name	Birth Date	Age	Sex	Post High School Student?
Spouse				Male ☐ Female ☐	
Child				Male ☐ Female ☐	Yes ☐ No ☐
Child				Male ☐ Female ☐	Yes ☐ No ☐
Child				Male ☐ Female ☐	Yes ☐ No ☐
Child				Male ☐ Female ☐	Yes ☐ No ☐

3. Other Insurance Information

Is your spouse employed? Yes ☐ No ☐	If Yes, name of employer:		
Does your spouse have a group health plan outside of this plan?	Yes ☐ No ☐	If yes, please indicate the coverage below.	
Medical Plan ☐	Effective date:	Single Coverage ☐	Family Coverage ☐
Dental Plan ☐	Effective date:	Single Coverage ☐	Family Coverage ☐

4. Health Insurance and Portability Act of 1996 Information

Did you have medical coverage prior to enrolling in this plan?	Yes ☐ No ☐		
If yes, Carrier Name:	Effective date:	Termination Date:	
Type of Enrollment: New Hire: ☐	Special Enrollment: ☐	Late Entrant: ☐	

This group plan is required to provide a "Special Enrollment" period for individuals who do not enroll in the plan at their first opportunity but subsequently lose their other source of coverage for a reason other than voluntary termination of coverage, or for marriage, birth, or adoption. A "Late Entrant" is someone who did not enroll in the plan at his or her first opportunity, but now seek coverage without a "Special Enrollment" event.

Qualifying Event: (i.e. marriage, divorce or legal separation, birth or adoption, or involuntary loss of coverage)

Hire Date: Month Day Yr

Is a Certification of Creditable Coverage Attached? Yes ☐ No ☐. If No, TRISTAR Benefit Administrators assumes that there is no creditable coverage. If a Certification of Creditable Coverage is provided, the plan pre-existing condition period, if applicable, may be partially or fully waived.

5. Life insurance Beneficiary (if applicable)

I hereby make the following beneficiary designation. If more than one person is named, percentage of benefit rather than dollars should be used. The beneficiary for Dependent Life Insurance shall be the insured Employee if surviving. Otherwise, the Dependent's estate subject to the Group Policy provisions. If the designation is a trust, and the trustee is not a financial institution, please forward a copy of trust agreement.

Beneficiary	Relationship

This shaded area to be completed by your employer

Employee Term Life $_____	Employee $_____	
Dependent Term Life $_____	Disability Benefit	Yes ☐ No ☐

6. Complete this information only if making a change.

☐ Name Change (Complete sections 1 and 8)			
Former Name:	New Name:		
☐ Change from Single to Family Coverage (Complete all sections)			
Reason for change:	Date of change: Month	Date	YR
☐ Change from Family to Single Coverage (Complete sections 1, 2, and 8)			
Reason for change:	Date of change: Month	Date	YR
☐ Adding Dependents with no change in Coverage (Complete all sections)			
Reason for change:	Date of change: Month	Date	YR
☐ Terminate a dependent (Complete section 1)			
Dependent(s) name:	Last date of Coverage: Month	Date	YR

7. Premium Only Plan

Group sponsored insurance premiums may be funded with pre-tax dollars. I authorize my employer to reduce my salary by the employee contribution amount, as designated by my employer; to cover the premium for my employer sponsored insurance plans in which I have elected to enroll.

Employee Signature	Date

8. Employee Signature

I understand that if I have made any false statements or misrepresentation or have failed to disclose or concealed any material fact TBA will be entitled to deny health care benefits. I agree that any surgeon, physician, dentist, pharmacist, nurse, hospital, or health care facility may furnish TBA with the diagnosis or medical records for any history of any past, present, or future treatments or conditions of all persons named herein. I agree, upon request, to furnish TBA with all information required to administer the health care plan. If the plan requires contributions by me, I authorize my employer to deduct them from my pay.

Employee Signature	Date