

## EXEC-U-CARE® MEDICAL REIMBURSEMENT INSURANCE EMPLOYEE ENROLLMENT FORM

**To avoid any delay in enrollment please ensure all fields are completed.**

Name of Employer \_\_\_\_\_ Employment Date (if applicable) \_\_\_\_\_

Employer's Federal Tax ID Number \_\_\_\_\_ Effective Date \_\_\_\_\_

Name of Insured \_\_\_\_\_

Employee  Surviving Spouse  Male

Insured Birthdate \_\_\_\_\_

Retiree  Board Member  Female

Social Security Number \_\_\_\_\_

Employee Email \_\_\_\_\_

Yes, I would like to be contacted via email  No, I would not like to be contacted via email

Spouse's Name \_\_\_\_\_

Spouse Birthdate \_\_\_\_\_

Spouse Social Security Number \_\_\_\_\_

Beneficiary for \$100,000 AD&D Benefit \_\_\_\_\_ Relationship \_\_\_\_\_

Dependent Name \_\_\_\_\_

Social Security Number \_\_\_\_\_

Date of Birth \_\_\_\_\_

Dependent Name \_\_\_\_\_

Social Security Number \_\_\_\_\_

Date of Birth \_\_\_\_\_

Dependent Name \_\_\_\_\_

Social Security Number \_\_\_\_\_

Date of Birth \_\_\_\_\_

Dependent Name \_\_\_\_\_

Social Security Number \_\_\_\_\_

Date of Birth \_\_\_\_\_

**Exec-U-Care Medicare Reporting**

**1a. Do you currently have Medicare Coverage? (please print)**

**Employee**     Yes     No

Name \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_

**Spouse**     Yes     No

Name \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_

**Dependent**     Yes     No

Name \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_

**Dependent**     Yes     No

Name \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_

**1b. If Yes, please complete Section 1b then proceed to question 2, if No please continue to question 2.**

**Employee**

Medicare ID# (HICN) \_\_\_\_\_ Effective Date Part A \_\_\_\_\_ Part B \_\_\_\_\_

Reason     Age     Disability     End Stage Renal Disease

**Spouse**

Medicare ID# (HICN) \_\_\_\_\_ Effective Date Part A \_\_\_\_\_ Part B \_\_\_\_\_

Reason     Age     Disability     End Stage Renal Disease

**Dependent**

Medicare ID# (HICN) \_\_\_\_\_ Effective Date Part A \_\_\_\_\_ Part B \_\_\_\_\_

Reason     Age     Disability     End Stage Renal Disease

**Dependent**

Medicare ID# (HICN) \_\_\_\_\_ Effective Date Part A \_\_\_\_\_ Part B \_\_\_\_\_

Reason     Age     Disability     End Stage Renal Disease

**2. Are you still working?**

**Employee**

Yes     No as of \_\_\_\_\_    If No     Retired     Leave of Absence     Terminated

**Spouse**

Yes     No as of \_\_\_\_\_    If No     Retired     Leave of Absence     Terminated

**3. Is your health coverage through COBRA?**

**Employee**

Yes as of \_\_\_\_\_     No

**Spouse**

Yes as of \_\_\_\_\_     No

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Exec-U-Care Office Use Only

Process Date \_\_\_\_\_

Certificate Mailed \_\_\_\_\_

Company Name \_\_\_\_\_ (Company) Group# \_\_\_\_\_

I certify that my eligible dependents and I are covered by a Base Health Plan as defined in the Employer's Participation Agreement and I hereby request to be insured under the group policy(ies) issued.

Signature \_\_\_\_\_

Date \_\_\_\_\_