LOUISIANA CLERKS OF COURT INSURANCE TRUST GROUP HEALTH, DENTAL & LIFE INSURANCE ENROLLMENT/CHANGE FORM

Group Health Plan #: *LCCIT707*
Group Life Plan #: *145101* Group Dental Plan #: *145101*

OFFICE USE ONLY:
PARISH # ____________
COV CODE: ____________
EFF DATE: ____/____/____

Enrollment: ☐ New ☐ Late ☐ Change in Coverage ☐ Cancellation ☐ Other: ____________

1. EMPLOYEE NAME (Last, First, Middle Initial)

2. SOCIAL SECURITY NUMBER ______/______/______

3. ADDRESS (Street, City, State, Zip Code)

4. HOME # ( ) -

5. WORK # ( ) -

6. PARISH

7. JOB TITLE

8. DATE OF FULL TIME EMPLOYMENT ____/____/____ (Month/Day/Year)

9. DATE OF RETIREMENT ____/____/____ (Month/Day/Year)

10. GENDER □ **Male** □ **Female**

11. BIRTHDATE ____/____/____ (Month/Day/Year)

12. MARITAL STATUS

13. GROSS MONTHLY SALARY $ ____________

14. CHECK COVERAGE(S) SELECTED FOR SELF

□ **Medical Option 1** □ **Medical Option 2** □ **Dental** □ **Basic Employee Life/AD&D** □ **Basic Dependent Life/AD&D**

□ **Additional Life for Employee** **Your requested amount** ____________

□ **Additional Life for Spouse** **Your requested amount** ____________ (May be up to half of amount on self) **Birth date** ____________

15. COMPLETE THE FOLLOWING FOR DEPENDENT COVERAGE **IF CHANGE, EFFECTIVE DATE:** ____/____/____

LAST NAME	FIRST NAME	BIRTH DATE	SSN	GENDER	Check Coverage Selected: Med 1	Med 2	Dental	Life	RELATIONSHIP	If Child is over 18 Please Check:
				☐ M ☐ F	☐	☐	☐	☐		☐ F/T Student ☐ Disabled
				☐ M ☐ F	☐	☐	☐	☐		☐ F/T Student ☐ Disabled
				☐ M ☐ F	☐	☐	☐	☐		☐ F/T Student ☐ Disabled
				☐ M ☐ F	☐	☐	☐	☐		☐ F/T Student ☐ Disabled
				☐ M ☐ F	☐	☐	☐	☐		☐ F/T Student ☐ Disabled
				☐ M ☐ F	☐	☐	☐	☐		☐ F/T Student ☐ Disabled

16. COVERAGE CHANGE IS □ **ADDITION** □ **DELETION - REASON FOR CHANGE:** ____________

Address to send dependent COBRA Election form for term: ____________

17. CHANGE NAME FROM: ____________ **TO:** ____________

18. ☐ **I DECLINE ALL COVERAGES OFFERED BY MY EMPLOYER--BASIC LIFE, ADDITIONAL LIFE, MEDICAL, AND DENTAL.**

19. ☐ **NOTICE OF CANCELLATION OF ALL COVERAGE** **EFFECTIVE DATE:** ____/____/____

☐ I hereby cancel the following coverage(s) only: ____________ **REASON FOR CANCELLATION:** ____________

MAIL FORMS TO: LCCIT C/O HUNT INSURANCE GROUP, LLC/HRH, PO BOX 12909, TALLAHASSEE, FL 32317-2909 OR FAX TO: 850-893-7245

**** SEE BACK FOR SIGNATURES AND ADDITIONAL INFORMATION ****

LOUISIANA CLERKS OF COURT INSURANCE TRUST

GROUP HEALTH, DENTAL & LIFE INSURANCE ENROLLMENT/CHANGE FORM

BENEFICIARY (IES) ☐ **CHECK BOX IF CHANGING BENEFICIARY - Use additional sheet if necessary**

NAME(S)	RELATIONSHIP	PERCENTAGE
______________________________	____________________	__________
______________________________	____________________	__________
______________________________	____________________	__________

ARE YOU OR ANY FAMILY MEMBERS COVERED BY ANY OTHER INSURANCE PLAN? ☐ Yes ☐ No

If yes, please provide information below:

WHO IS COVERED? ______________________________ IDENTIFICATION #: ______________

INSURANCE CARRIER NAME & ADDRESS: ____

____

I hereby certify that this foregoing information is true and correct to the best of my knowledge. I hereby accept the form(s) of group insurance presently contracted for me by my employer with the Louisiana Clerks of Court Insurance Trust in the amount(s) for which I am or may become eligible and authorize until revoked by me in writing the deduction by employer from my earnings of amounts sufficient to cover my contributions toward the premium under the said group insurance contract(s), if any. I have read the statements on this form.

EMPLOYEE SIGNATURE: ______________________________ DATE: _____/_____/_____

EMPLOYER SIGNATURE: ______________________________ DATE: _____/_____/_____

I understand and agree that any misstatement on this form may result in denial of benefits and/or termination of coverage/membership. I agree to be bound by the group contract’s terms and conditions. I understand that this application is hereby made a part of the group contract. I understand that 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.

Declination of Coverage

If you are declining enrollment for yourself or your dependents because of other health insurance coverage, you may in the future be able to enroll yourself and your dependents in this plan, provided that you request enrollment, by submission of an individual application to your Employer, 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 enroll yourself and your dependents, provided that you request enrollment, by submitting an individual application to your Employer, within 30 days after the marriage, birth, adoption or placement for adoption.

If you and/or your dependents have coverage under another health plan and decline enrollment, you are required to complete the appropriate section of this form and return it to your Employer. If you fail to comply with these standards, you may not be entitled to special enrollment when your other coverage terminates. Please note that you will not be entitled to special enrollment if loss of eligibility for coverage is the result of termination of coverage for failure to pay premiums on a timely basis or for cause. Voluntary Termination of Coverage does not constitute loss of eligibility of coverage.

If declining coverage for Life, I understand that if I want to become insured later, I will be required to provide satisfactory Evidence of Insurability, and that the insurance company will have the right to refuse my request for insurance. I understand that Life coverage(s) not specifically elected will not become effective, even if not marked as declined.