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**WARNING:** Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an Insurer or health benefit plan, submits an application or files a claim containing false or deceptive statements is guilty of insurance or health care fraud under state and/or federal law.

**ANTIOCH UNIVERSITY EMPLOYEE APPLICATION**

**For Office Use Only**

Group Account No. 10225 Date Coverage Effective \_\_\_\_\_ Campus Plan No. \_\_\_\_\_

**Action:**  New Employee  Annual Enrollment  Info/Status Change

**PLEASE READ CAREFULLY AND COMPLETE IN INK TO PREVENT YOUR COVERAGE FROM BEING DELAYED.**

**1 Employee Information (Please Print in Ink):**

Name \_\_\_\_\_ Social Security Number \_\_\_\_\_  
Last First Middle Initial

Home Address \_\_\_\_\_ Telephone ( ) \_\_\_\_\_  
Street City State Zip

<b>Employee Date of Birth</b> ____/____/____ Mo. Day Yr.	<b>Marital Status</b> <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Domestic Partner <small>Complete Supplemental Information – Domestic Status Form</small>	<b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Employment Status</b> <input type="checkbox"/> Active Employee <input type="checkbox"/> Retiree	<b>Date Hired</b> ____/____/____ Mo. Day Yr	<b>COBRA Election (if applicable)</b> ____/____/____ Mo. Day Yr
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**SELECT PLAN/COVERAGE**

- Vision-Employee Only
- Vision-Employee + 1 Dependent
- Vision-Employee + 2 or more Dependents
- Dental-Employee Only
- Dental-Employee + 1 Dependent
- Dental-Employee + 2 or more Dependents
- Short Term Disability  
*(Ohio & NH BW Hourly Employees Only)*

**Supplemental Plan**

- Employee Only
- Employee + 1 Dependent
- Employee + 2 or more Dependents

**LIFE INSURANCE**

<b>Name of Beneficiary:</b>	<b>Relationship:</b>	<b>Beneficiary SSN:</b>
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Full Name	Date of Birth	Gender		SSN	*Relationship
		Male	Female		
Spouse/Domestic Partner					
<b>Other Dependent(s)</b>					

\*C=Child / SP=Step-child / FC=Foster Child / DC=Domestic Partner Child

Please attach to this application copies of any court orders or legal documents creating this relationship. Dependents are covered up to midnight before their 25<sup>th</sup> birthday as long as qualified as a dependent under the IRS guidelines.

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**OTHER INSURANCE**

Please provide the person(s) name(s) and the name of any other health insurance for any of the previously name individuals.

Name(s) or person(s) with other insurance:	Date of Birth	Relationship
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Type of Coverage: <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Type of Coverage: <input type="checkbox"/> Other <input type="checkbox"/> Medicaid
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Name/Address of other carrier: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Read this Statement and Authorization Carefully**

I hereby request coverage and/or insurance and authorize that any requested contribution for the coverage and/or insurance to which I may be entitled be deducted from my earnings. I am employed by the employer shown and am working at least the number of hours per week required by my Employer and shown on the Employer Application. I authorize (1) any physician, hospital, or facility, (2) any insurance company or health care plan, (3) any state or federal agency providing health care benefits; and (4) any employer to provide MedBen or its legal representative any information in its possession which is relevant to this application for coverage and/or insurance regarding myself or my listed Dependent(s). This information will be used to determine the eligibility for coverage and/or benefits for myself and my listed Dependent(s) and will be utilized by employees, agents and business associates of MedBen with responsibility for (1) reviewing applications and determining eligibility for coverage and/or insurance, (2) process and/or payment of claims, and (3) any health care operations. I hereby authorize and release any provider of health care services, claim administrators, insurers, reinsurers, pharmacy benefit managers or consultants, stop loss carriers, disease management service and/or wellness benefit providers or consultants, and others who have a legitimate need for such information for the purpose of review, investigation, or evaluation of a claim, health plan service or any other health care operation, to supply each other with information about the health status of, and health care services provided to, me and my listed Dependent(s). This authorization is effective on the date signed and shall remain in effect until the date such coverage and/or insurance is terminated. (You, or any individual authorized by law to act on your behalf, have a right to receive a copy of this authorization). A photographic copy of this authorization shall be as valid as the original. I understand that if I fail to provide this authorization, MedBen will be unable to process my application for coverage and/or insurance. I further understand that I have the right to revoke this authorization by submitting such revocation to the Chief Privacy Officer at MedBen at the address listed on this application. Such revocation will not be effective to the extent that action has been taken in reliance upon this authorization prior to receipt of my revocation or to the extent that my coverage or a claim may be contested under applicable law. I hereby certify that I have personally answered all of the questions on this form and that my answers are true and complete to the best of my knowledge and belief. I have legal proof which I can furnish upon request of my relationship to any person listed as a Dependent(s) above. I understand any misstatements or failure to report may be used as a basis for rescission or cancellation of the coverage and/or insurance for me and my Dependent(s), if any.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

Human Resource Verification \_\_\_\_\_ Date \_\_\_\_\_

Life start date: \_\_\_\_\_ Life Benefit: \_\_\_\_\_ Life Class: \_\_\_\_\_

**I understand that if, upon receipt, the signature is more than 60 days old, a new application will be requested.**