NIPPON LIFE INSURANCE COMPANY OF AMERICA

EMPLOYEE GROUP ENROLLMENT FORM

NAME OF EMPLOYER: _____

Select One: ☐ **New Enrollment** ☐ **Enrollment Change**

Check Box(es) that apply:
- ☐ **Reinstatement**
- ☐ **Add Newborns**
- ☐ **Special Enrollment (attach Certificate of Creditable Coverage)**
- ☐ **Late Enrollment (attach medical application enrollment form)**

Current Status

Check Box(es) that apply:
- ☐ **Currently working**
- ☐ **COBRA**
- ☐ **Continuation**
- ☐ **Disability**
- ☐ **Retired**
- ☐ **Other leave _____**

Employee's Name (Last, First, MI)	Social Security Number

Employee's FULL Address

City State Zipcode

Birthdate / /

Marital Status: ☐ Single ☐ Married (Date) _____ ☐ Divorced ☐ Widowed ☐ Separated

Date of Full Time Employment / /

Number of Hours Worked per Week

Sex: ☐ Male ☐ Female

Life Benefit:

Base Annual Salary

Occupation

☐ hourly ☐ salaried

Beneficiary Designation: (attach additional page if necessary)

Full Name _____ Relationship _____

Coverage Applying For:	Employee	Child(ren)	Spouse
Life	☐	☐	☐
Dependent Life	☐	☐	☐
Optional Life Benefit	☐	☐	☐
Medical	☐	☐	☐
Dental	☐	☐	☐
Vision	☐	☐	☐
Short Term Disability	☐		
Long Term Disability	☐		

For Dual Deductible Plans, what deductible amount is chosen?

_____

Waiver: Coverage can only be declined if you pay part or all of the premium

	Employee	Child(ren)	Spouse
Life	☐		
Dependent Life		☐	☐
Medical	☐	☐	☐
Dental	☐	☐	☐
Vision	☐	☐	☐
Short Term Disability	☐		
Long Term Disability	☐		

I have been offered the above coverage and wish to decline enrollment for the following reason(s):
- ☐ Covered under another insurance plan
- ☐ Other (please explain)

_____

COMPLETE ONLY IF APPLYING FOR DEPENDENT COVERAGE

Dependent's full Name	Sex	Relationship	Birthdate	Full Time Student
	☐ F ☐ M	Spouse		
	☐ F ☐ M	☐ Child/Step child ☐ Other		☐ Yes ☐ No
	☐ F ☐ M	☐ Child/Step child ☐ Other		☐ Yes ☐ No
	☐ F ☐ M	☐ Child/Step child ☐ Other		☐ Yes ☐ No

Please list additional dependents on a separate sheet of paper and staple to this form.

PLEASE READ REVERSE SIDE FOR MORE IMPORTANT INFORMATION REGARDING YOUR RIGHT TO SPECIAL ENROLLMENT AND PRE-EXISTING CONDITION LIMITATIONS, THEN SIGN AND DATE ON THE DESIGNATED LINES.

THIS FORM WILL NOT BE ACCEPTED BY NIPPON UNLESS SIGNED AND DATED BY THE INSURED/EMPLOYEE

I hereby apply for insurance to which I am now or may become entitled under the provisions of the Group Insurance issued by the Insurance Company. I authorize my employer to deduct the required premium contribution, if any, from my earnings. I understand that my application for any non medical coverage is subject to approval by the Insurance Company. I understand that my medical coverage, and that of my dependents, if any, will be subject to the pre-existing condition provision specified in the Certificate, and that this provision has been fully explained to me. I understand that in the event I desire at a later date, such coverage, previously cancelled or refused, I will be required to furnish a late enrollee form and may be subject to an 18-month pre-existing condition exclusion.

I am applying for coverage under the Insurance Company's Precertification conditions. I authorize any physician, medical practitioner, hospital, clinic, or medical-related facility or insurance company having information available as to diagnosis, treatment and prognosis regarding any physical, mental, drug, or alcohol condition and/or any treatment of myself or my insured dependents to give/allow the Insurance Company or their legal representatives any and all such information including but not limited to Precertification of outpatient procedure or service and hospital admission, Continued Stay Review, On-Site concurrent Review and patient visitation while I or my insured dependents are or have been a patient of a physician, hospital, clinic or medical-related facility. I understand that failure to precertify results in reduced or no benefits.

Any information obtained will not be released by the Insurance Company to any person or organization except to persons or organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required or as I may further authorize. I understand that this information obtained by the Insurance Company will be used to determine appropriate and accurate medical charges.

I hereby declare that the foregoing statements and answers made by me on behalf of myself and my dependents, if applying, are complete and true, and that they are correctly and fully recorded, and that no material circumstance or information has been intentionally withheld or omitted concerning myself and my dependents, if any, past and present state of health, and I agree that the answers and statements herein shall form a part of the certificate. I understand that any misstatements or failure to report information may be used as the basis of rescission of Insurance for myself or my dependents, if any. I also understand that insurance will not be in force until the application is approved b the Insurance Company.

Furthermore, I hereby authorize any physician or practitioner, hospital, or other organization, institution, or person that has any medical records or knowledge of me or my family to give to the Insurance Company or its Authorized Administration such information (photocopy of this authorization shall be valid as the original).

_____ _____

Signature of employee (and parent of applicant if under age 18) Date

PLEASE MAIL TO: TOTAL PLAN SERVICES P.O. BOX 36631 DALLAS, TX 75235

FOR OFFICE USE ONLY

Effective Date Group Number Plan