Custom Benefit Administrators

GROUP ENROLLMENT FORM

For CBA Use Only
Eff. Date ____
Group No. ____

Employer Name: ____ **Location:** ____

Last Name ____ First Name ____ MI ____ Date of Birth __/__/__ Sex ____

Street Address ____

City ____ State ____ Zip ____

Social Security No. __/__/__

Date of Employment __/__/__

Dependents to be covered: Include last name if different from employee's.

Name of Dependent	Birthdate	Sex
Spouse	/ /	
Child	/ /	
Child	/ /	
Child	/ /	
Child	/ /	
Child	/ /	

Marital Status:
____ Single ____ Married
____ Divorced ____ Widow

Telephone Number __/__/__

Job Title ____

Hours worked per week ____

Benefits Requested (Mark with an 'X')

____ Single Medical ____ Family Medical
____ Single Dental ____ Family Dental
____ Single Vision ____ Family Vision

If you request medical insurance you must fill out the back of this form.

OTHER COVERAGES: As of your effective date, will there be any other group insurance in effect on you or your dependents? YES _____ NO _____

If Yes, employer's name: ____

Primary insured: ____

Please indicate if other coverage is:

Medical Insurance:	Single _______	Family _______
Dental Insurance:	Single _______	Family _______
Vision Insurance:	Single _______	Family _______

Family Members covered under other insurance: ____

WAIVER OF BENEFITS

I, the undersigned, an employee of the above named policy holder, hereby certify that I have been given an opportunity to apply for group insurance benefits as offered by my employer and after careful consideration, I hereby waive my right to:

____ Single Medical ____ Family Medical ____ Single Dental ____ Family Dental ____ Single Vision ____ Family Vision

Reason for waiving coverage: ____

MEDICAL RELEASE / AUTHORIZATION

I authorize any physician, medical practitioner, hospital, clinic, other medical related facility, insurance or reinsurance company to release to Custom Benefit Administrators or their legal representative, personal health information necessary for benefit determination, payment, treatment or plan operations. Information may include, but is not limited to, precertification of hospital admissions, Continued Stay Review, On-Site Concurrent Review and Retrospective Review. Also included is medical history or diagnostic and therapeutic information which may contain treatment of mental health, alcohol or drug abuse, developmental disabilities and HIV testing.

Any information obtained will not be released by Custom Benefit Administrators to any person or organization except to reinsuring companies, or any other persons or organizations performing business or legal services in connection with my application, claims or as may be otherwise lawfully required. For more information on possible release of information, I can contact Custom Benefit Administrators for a copy of their privacy policy. I will be notified of any subsequent changes to that policy.

I understand that this information obtained by Custom Benefit Administrators, Inc. will be used to determine appropriate and accurate medical benefits.

I further authorize Custom Benefit Administrators to pay benefits directly to the provider unless otherwise indicated at the time of claim submission.

I agree that this authorization is valid for one year from the signature date. Authorization may be revoked by written request.

I hereby verify that the information listed above is true and accurate to the best of my knowledge.

Signature of Employee (Required) ____ **Date Signed** ____

305 5th Avenue South * P.O. Box 1385 * La Crosse, WI 54602-1385 * (608) 784-2442

Merck Medco's PAID Prescription, L.L.C.
Pre-Existing Condition Affidavit & Questionnaire

Employer Name: ______________________ Effective Date of Coverage: ____________

Name: ______________________ Cardholder #: ____________
Last Name First MI

Address: ______________________
Street City State Zip

Phone Number: ( ) ____________ Group Number: CBA5749

Your application for enrollment in the plan sponsor's medical plan included prescription drug coverage that is administered through PAID Prescriptions, L.L.C. In order to better serve you and your plan sponsor, we ask that you list any medications you or your eligible dependents are currently taking to treat any ongoing medical condition(s). This information is required for the proper administration of you plan sponsor's prescription drug program, and is held in confidence.

PLEASE COMPLETE THIS SECTION FOR ALL ELIGIBLE PARTICIPANTS. List all medications each participant is taking.

1. Cardholder: ______________________ Medication(s) ____________
Last Name First MI

2. Spouse: ______________________ Medication(s) ____________
Last Name First MI

3. Dependent: ______________________ Medication(s) ____________
Last Name First MI

4. Dependent: ______________________ Medication(s) ____________
Last Name First MI

5. Dependent: ______________________ Medication(s) ____________
Last Name First MI

Please use additional form(s) if the space provided above is not sufficient.

* * * * IMPORTANT * * * *

THIS SECTION TO BE COMPLETED BY CBA

Pre-existing waiting period: From ____________ To ____________

Signature of Employer
or Plan Sponsor Rep: ______________________ Date Signed: ____________

ACCURACY OF INFORMATION

I do hereby state, for myself and those of my eligible dependents listed, that the information provided above is correct to the best of my knowledge as of the date signed. I understand that said information will be used by PAID Prescriptions, L.L.C. to determine eligibility for coverage, and make the appropriate payment for covered benefits. I further authorize PAID Prescriptions, L.L.C. to furnish and deliver to the medical plan sponsor or its representatives, said information and also the costs of such benefits, payments made or denied, dates of services, recipients of payments and any other claim information that is requested, I further agree to hold PAID Prescriptions, L.L.C., its directors, officers, employees and agents harmless from any liability for the release of said information. I understand that the giving of inaccurate or incorrect information on this application may result in a denial of benefits and that I will be responsible for any and all claims that may occur as a result of my failure to provide information that is true and correct.

I HEREBY APPLY FOR ENROLLMENT SUBJECT TO THE TERMS AND CONDITIONS STATED ABOVE.

Signature: ______________________ Date: ____________

NOTICE OF SPECIAL ENROLLMENT PERIOD RIGHTS

I am aware that if I refuse coverage for myself and/or my dependents (including my spouse) when first eligible because I have other coverage, I may later apply for coverage for me and/or my dependents if eligibility is lost under that other coverage, if the employer stops contributing toward the other coverage or if adding a dependent due to marriage, birth, adoption or placement for adoption. Loss of eligibility may result from one of the following:

1. Your spouse loses coverage due to job termination or has a reduction in hours to a status that is ineligible for coverage;
2. My spouse and I divorce;
3. My spouse dies; or
4. The expiration of COBRA for a previous employer.

I am aware that if I refuse coverage for myself and/or my dependents (including my spouse) when first eligible because I do not want coverage for whatever reason, I may later apply for coverage for myself and/or my dependents with:

1. Marriage; or
2. The birth, adoption or placement for adoption of a child.

In addition, you may add a new dependent to your plan as a result of a marriage, birth, adoption or placement for adoption. Application to add a new dependent must be made within 30 days of the event.

If you qualify for enrollment under any of the above exceptions you must complete and return the signed application to Custom Benefit Administrators (CBA) or your employer within 30 days of the qualifying event. When adding a dependent to your existing policy, you must complete and return a signed change form to CBA or your employer within 30 days of the marriage, birth, adoption or placement for adoption.

If you have any questions regarding special enrollment period rights, you may contact Custom Benefit Administrators at 1-800-944-2188.

PRE-EXISTING CONDITION GENERAL NOTICE

When your coverage becomes effective, there will be exclusions on sickness and injury charges received for any medical condition(s) that existed prior to coming on this plan. No benefits will be paid for charges received for the medical condition(s) until the end of the pre-existing condition exclusion period. This pre-existing condition exclusion does not apply to pregnancy or to a child enrolled within 30 days of birth, adoption or placement for adoption.

A pre-existing condition is a physical or mental condition, regardless of the cause of the condition, for which medical advice, services, medications, diagnosis, care or treatment was received within the 6 month period prior to your date of hire in an eligible status. In the case of a late enrollee or special enrollee, this period begins on your effective date. The pre-existing condition exclusion may last up to 12 months (18 months for a late or open enrollee, if offered by the plan) from your date of hire in an eligible status or from your effective date (for a late, open or special enrollee, if offered by the plan).

You have the right under federal law to have the plan's pre-existing condition exclusion reduced by the number of days of creditable coverage you can demonstrate. Creditable coverage is a period of continuous coverage during which there has not been more than a 63 day lapse (not including waiting periods). If the amount of creditable coverage is equal to or greater than your pre-existing condition exclusion period, this exclusion will be eliminated.

Creditable coverage may be shown by sending a certificate of creditable coverage from a prior plan or health insurance issuer. If you did not receive or do not have a certificate from the prior plan, federal law requires your prior plan to provide you with one upon receiving your written request within 24 months of the date your coverage ended. If you are unable to obtain a certificate after requesting one in writing, this plan may assist you in obtaining the necessary information to demonstrate creditable coverage under the prior plan.

If you have any questions about the pre-existing condition exclusion or creditable coverage, you may contact Custom Benefit Administrators at 1-800-944-2188.