



# Group Insurance Trust (GIT)



## BENEFITS ENROLLMENT FORM

**Dealership Name:** \_\_\_\_\_  
**County:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **Dealer #:** \_\_\_\_\_  
**PO Box :** \_\_\_\_\_ **Store Location:** \_\_\_\_\_  
**City:** \_\_\_\_\_  
**State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_ ---

**DEALER PRIMARY CONTACT INFO:**  
**Name:** \_\_\_\_\_  
**Title:** \_\_\_\_\_  
**Phone #:** (    )    --  
**Fax #:** (    )    --  
**Email:** \_\_\_\_\_

### PLEASE CHECK APPROPRIATE BOXES

NEW ENROLLMENT		Remove or Terminate	Requested Eff. Date	Changes	Req. Eff. Date
New Member	<input type="checkbox"/>	Employee	/ /	Add Spouse	/ /
Date of Hire	/ /	Spouse	/ /	Add Child/ren	/ /
Effective Date of Coverage	/ /	Child/ren	/ /	Change to Family Coverage	/ /

### EMPLOYEE INFORMATION

### THIS SECTION MUST BE FILLED OUT - PLEASE PRINT

**Marital Status:** Single: \_\_\_ Married: \_\_\_ Legally Separated: \_\_\_ Divorced: \_\_\_  
**Social Security #:**    ---    ---    **Job Title:** \_\_\_\_\_  
**Last Name:** \_\_\_\_\_  
**First Name:** \_\_\_\_\_  
**Middle Name / Initial:** \_\_\_\_\_ **Suffix:** \_\_\_\_\_  
**Date of Birth:**    /    /    \_\_\_\_\_  
**Sex:**    Male: \_\_\_    Female: \_\_\_

**Email:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**PO Box / Apt #:** \_\_\_\_\_  
**City:** \_\_\_\_\_  
**State:** \_\_\_\_\_  
**Zip:** \_\_\_\_\_  
**Phone #:** (    )    ---

### DEPENDENT(S) TO BE COVERED - PLEASE PRINT

Relationship	Last Name	First Name	Social Security #	Date of Birth	College Name	Exp Grad Date	SEX	
							M	F
Spouse			-- --	/ /		/ /		
Child			-- --	/ /		/ /		
Child			-- --	/ /		/ /		
Child			-- --	/ /		/ /		
Child			-- --	/ /		/ /		



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### MEDICAL PLAN, HIGH DEDUCTIBLE & DENTAL OPTIONS

Enrollment Type	Medical Plan Options				High Deductible Options		Dental Options	
	PPO	EPO 80%	EPO 100%	POS (WNY)	HSA	HRA	Schedule Plan	PPO - High Option
Employee Only								
Employee & Spouse								
Employee & Child/ren								
Family								

### LIFE INSURANCE BENEFITS

Beneficiary Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 (Full legal name)

Dependent Life ( I elect the following)      Spouse Only       Child/ren Only       Family

New York State Disability      Employee Only

Voluntary Programs      Employee Only       (Additional Forms To Be Completed)

### WAIVER OF COVERAGE SECTION-MUST BE COMPLETED IF WAIVING COVERAGE

*I was given the opportunity to enroll in the plans offered above by the GIT and I refuse as follows:*

#### Reason for Refusal (Check One)

- Other group coverage through my spouse's employer. Please provide insurance carrier name & group # (below).
- Other group coverage through another organization, (e.g. Union Plan). Please provide insurance carrier name & group # (below).
- Other: Healthy NY Policy # \_\_\_\_\_ Carrier Name: \_\_\_\_\_ Group #: \_\_\_\_\_
- Other reason (Explain) \_\_\_\_\_

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### ACCEPTANCE OF COVERAGE AND AUTHORIZATION TO RELEASE INFORMATION

I accept and acknowledge all coverage elected on this Benefits Enrollment Form. Further, I authorize any insurance carrier or entity to provide the GIT access to claims history for myself and any dependents that includes but is not limited to diagnosis and procedure codes. I understand that GIT and my health insurance carrier will comply with HIPAA and Federal and State laws governing confidentiality and release of PHI unless otherwise provided by law. I acknowledge that all information that I provided is truthful and accurate.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_