Cypress BENEFIT ADMINISTRATORS

P O Box 7020 Appleton, WI 54912 Phone: 877-236-0844 Fax: 866-542-1874

ENROLLMENT FORM

GROUP NAME: BLUE OX ENTERPRISES, LLC **GROUP # B09**

Social Security Number	Last Name	First Name	Mi	Male / Female

Date of Hire	Hours Worked Per Week	Date of Birth	Email Address

Street Address	Marital Status: (circle one) Single Divorced Married Widowed Other	Date Of Birth

City	State	Zip	Phone Number

EMPLOYEE INFORMATION

COVERAGE ELECTION (please circle)

MEDICAL PLAN: Low	SINGLE	EMPLOYEE & SPOUSE	EMPLOYEE & CHILD(REN)	FAMILY
_____ **I <u>WAIVE</u> ALL MEDICAL COVERAGE –Please sign below.**				

MEDICAL PLAN: High	SINGLE	EMPLOYEE & SPOUSE	EMPLOYEE & CHILD(REN)	FAMILY
_____ **I <u>WAIVE</u> ALL MEDICAL COVERAGE –Please sign below.**				

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DEPENDENTS (enrolling in plan)

	Sex	Last Name	First Name	M.I	Birth Date	Social Security Number	Other Insurance
Spouse	M/F						Y/N Fill In Below Table
Child	M/F						Y/N Fill In Below Table
Child	M/F						Y/N Fill In Below Table
Child	M/F						Y/N Fill In Below Table
Child	M/F						Y/N Fill In Below Table

OTHER COVERAGE INFORMATION

This section must also be filled out for anyone having other coverage, including Medicare coverage

Name of Covered Person	Effective Date	Name of Carrier	Name of Policy Holder

(1) I am enrolling for the benefits indicated in the "Coverage Election" section. If required, I authorize deductions from my earnings. (2) By completing the "Waiver of Coverage", I understand I am refusing coverage and that there may be penalties if I decide to reapply at a later date. (3) I hereby authorize any licensed physician, hospital, clinic, or other medical or medically related facility, insurance company, the Medical information Bureau, or other organization, institution, or person, that has any records or knowledge of me and/or my dependents' health, to give to Cypress Benefit Administrators or the reinsurer any such information. (4) I also authorize Cypress Benefit Administrators or the reinsurer to release any information regarding me and/or my dependents to the Medical Information Bureau and to other carriers through which I have policies or to whom I may apply or to whom a claim for benefits may be submitted. (5) I hereby certify that all the information shown above is true and correct to the best of my knowledge. I also understand that any false information listed will nullify this application and the coverage for which I am applying. Cypress Benefit Administrators has the right to rescind coverage should the above information prove to be not complete or accurate.

Employee Signature_____ Date_____

Employer Signature_____ Date_____