Integrity Administrators, Inc.
Enrollment Application

ER #		DEPART.	
EFF.		CLASS:	
MED ☐ DEN ☐ VIS ☐ LTD ☐ STD ☐ OTHER ☐			
TERM LIFE ☐	AMT.		

INDICATE REASON FOR APPLICATION

☐ New Enrollment ☐ Late Enrollment ☐ Re-enrollment ☐ New Hire
☐ Family Addition
- ☐ Add Spouse: (List Name Below) Date of Marriage: _____
- ☐ Add Dependents: (List Names Below) Date of Birth or Adoption: _____
- ☐ Terminate Coverage for: Spouse or Dependents listed below.

☐ Information or Coverage Change:
- ☐ Change Address: (Enter New Address Below)
- ☐ Change Name: (Former Name) _____ (Enter New Name Below)

Social Security Number - -	Last Name	First Name	M.I.

Street Address	Apt.	City	State	Zip Code

Home Phone ( )	Work Phone ( )	Company Name	Part Time? ☐ Yes ☐ No

Date of Birth	Sex ☐ Male ☐ Female	Occupation / Job Title	Date Hired	Salary $ ☐ Mo. ☐ Hr.

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced Spouse's Social Security # - -

Email Address (Optional):

Is the Employee actively at work and all Dependents are performing normal duties? ☐ Yes ☐ No

Do you or your dependents have other medical coverage? ☐ Yes ☐ No
Name of the carrier: Policy #:

Is the Employee or Dependents hospital confined? ☐ Yes ☐ No

Dependent Information

☐ YES, I wish to enroll my dependents. ☐ NO, I DO NOT wish to enroll my dependents. Complete Declination below.

	Add/ Delete	Last Name	First Name	M.I.	Date of Birth	Age	Sex M/F	Social Security #
Spouse								
Child								
Child								
Child								
Child								
Child								

Life Insurance Beneficiary: Last Name	First Name	M.I.	Relationship	Age

Authorization and Acknowledgement

I am applying for Group Benefits as provided by my employer and authorize my employer to deduct from my earnings the contributions required for my own coverage and dependent coverage if applicable. To the best of my knowledge the information contained herein is true and accurate. I hereby attest that the employees and dependents submitted for coverage meet all eligibility requirements set forth in my Employer's Plan Document.

I also hereby authorize any physician, practitioner, hospital, clinic or other medical or dental provider who has treated me or any of my dependents for any medical, surgical or dental condition to release information regarding that condition to Integrity Administrators, Inc.

I have read and understand the HIPAA Notice of Privacy Practices as printed on the back of this enrollment application.

Typing your name is the equivalent to an electronic signature.

X /s/ _____ _____
Signature Date

COVERAGE DECLINATION: To be completed if any coverage is declined or refused by an eligible employee and/or their eligible family member.

MEDICAL COVERAGE (CHECK if declined)
I decline coverage for:
☐ Myself
☐ Spouse
☐ Child
☐ Spouse & Child

DENTAL COVERAGE (CHECK if declined)
I decline coverage for:
☐ Myself
☐ Spouse
☐ Child
☐ Spouse & Child

LIFE INSURANCE (CHECK if declined)
I decline coverage for: ☐ Myself ☐ My Dependents

REASON FOR DECLINING MEDICAL, DENTAL AND/OR LIFE COVERAGE
☐ Covered by spouse's group coverage-Carrier's name: _____
☐ Covered by Medicare
☐ Other (explain) _____

I acknowledge that my employer has explained the available coverages to me, and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have declined to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage. BY DECLINING THIS GROUP HEALTH COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP HEALTH COVERAGE ELSEWHERE) I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT A SPECIFIED LENGTH OF TIME, AS STATED IN THE PLAN DOCUMENT, FROM THE DATE OF THIS APPLICATION TO BE ENROLLED IN THIS GROUP HEALTH AND/OR GROUP LIFE INSURANCE PLAN. PRE-EXISTING CONDITIONS, WHEN ENROLLED IN THIS GROUP PLAN, WILL NOT BE COVERED FOR THE PERIOD OF TIME AS STATED IN THE PLAN DOCUMENT.

X /s/ _____ _____
If declining coverage for employee/dependent(s), please sign here Date

Integrity Administrators, Inc. P O Box Sacramento, CA 95813 - 3128 (916) 921 - 3388 or (800) 562 - 9383 Fax (916) 921 - 3383

Distribution: White – Administrator / Yellow – Employer / Pink - Member

NOTICE OF PRIVACY PRACTICES AND PROTECTION

This Privacy Notice is provided for your information – keep a copy of it for your records.
No response is required or requested.

Your Privacy Is Important To Us - We value our relationship with our clients and are dedicated to providing them with exceptional service and competitive product offers. As part of our dedication to servicing your insurance needs, we are committed to protecting the confidentiality of our client's nonpublic personal information. This Privacy Notice will help you understand what type of information we collect about insured individuals, how the information we collect is used, and what measures we take to protect that information.

Information We Collect – Depending on the type of product or service, we collect nonpublic personal information about insured individuals that may include:

- Address
- Telephone number
- Social Security Number
- Account Information
- Income
- Employment
- Health Status, and
- Other personal information relevant to their coverage.

We collect such information primarily from information we receive from individuals, this application, or other forms. We may also collect information through telephone conversations or other electronic means, such as Internet "cookies' (data stored on a computer by an Internet browser when you use the Internet to access our website) that may be used to track website usage, remember passwords clients create, and provide clients with website content specific to their needs and interests. We may also obtain information from third parties such as employers, non-affiliated insurers, physicians, hospitals and other medical providers.

Your Information is Protected – We restrict access to nonpublic personal information to those employees who need to know that information to provide products or services to our customers. We maintain physical, electronic, and procedural safeguards that comply with federal and state regulations to guard such information. Our employees access information about insured individuals only when such access is necessary to conduct our business. For example, we may access information to offer other compatible products or services we provide, to process client requests, and to administer our products or services. Our employees are required to maintain the confidentiality of nonpublic personal information and to follow policies we establish to secure confidentiality.

Additionally, we require third parties to whom we disclose nonpublic personal information, or who receive or handle such information on our behalf, to adhere to our standard of privacy protection and to establish information security procedures.

Disclosure – We do not disclose any nonpublic personal information about our clients or former clients to anyone, except as permitted by law. Information will only be disclosed for such purposes as conducting and auditing our business, the business of affiliated organizations, responding to requests from government authorities, or as authorized or requested by an insured individual. Such disclosures include, but are not limited to:

- Affiliates – we may provide information to affiliated companies to enable them to provide business services for us such as claims pricing, underwriting, and maintenance of your accounts, and to offer products and services we provide.
- Agents and Brokers – we may provide information to enable your agent or broker to provide business services to you as requested by your employer.
- Government Entities – we may provide information upon request from a State Department of Insurance or other government entity. The purpose for the request may be to prevent fraud, conduct and audit of our business practices, or for any other reason for which the government entity is legally permitted to request information.
- Servicing organizations – we may provide information to servicing organizations such as, reinsurers, managing general underwriters, attorneys, accountants, actuaries, underwriters, PPO/UR companies, and other such organizations to enable them to provide business services for us.

We do not share, trade, sell, exchange or in any other way disclose nonpublic personal information except as stated above or to otherwise conduct the business of insurance.

Notification of Breach of Unsecured PHI – If PHI that we or any of our business associates uses or discloses is "breached" within the meaning of the notification requirements of the Privacy Rule, then, in accordance with HIPAA and your Plan's policies and procedures, we will provide the required notification to those individuals who have been affected by the breach, the Department of Health and Human Services and to any other necessary parties.

About this Privacy Notice – The examples contained in this Privacy Notice are provided as illustrations, and are not a comprehensive account of the rights of a party under applicable federal and state laws. The policies and protections indicated in the Privacy Notice will remain effective even after an individual's coverage is terminated to the extent we retain information about that individual. We may change this Privacy Notice at any time and will inform you of any changes as required by law. Other applicable privacy protections may exist under state laws and we will comply with all applicable state laws when we disclose information about individual insureds.

For additional information, contact us at:
Integrity Administrators
1787 Tribute Rd, Ste. E
Sacramento, CA 95815
or
P.O. Box 13128
Sacramento, CA 95813-3128
or
www.integrityadmin.com