



UNIVERSITY OF NOTRE DAME APPLICATION FORM

EMPLOYEE INFORMATION

NAME (Last) (First) (MI) Home Phone Office Phone MARITAL STATUS CHANGE: REASON FOR CHANGE: SOCIAL SECURITY NUMBER EMPLOYMENT DATE (MM/DD/YY)

BENEFITS

MEDICAL CARE Type of Coverage If you selected No Coverage: DENTAL CARE Type of Coverage VISION CARE Type of Coverage

EMPLOYEE AND FAMILY INFORMATION

Table with columns: NAME: First, MI Last; SSN; DATE OF BIRTH MM/DD/YY; Relationship; SEX; Disabled Y/N; FULL-TIME STUDENT; MED Y/N; DENTAL Y/N; VISION Y/N

MISCELLANEOUS INFORMATION

Have you ever been in the medical plan you've selected before? Will you, your spouse or dependent(s) be covered by Medicare or any other medical insurance at the time you are enrolled in this plan?

If I elect coverage, I hereby authorize all hospitals, physicians, medical service providers, pharmacists, employers and all other agencies or organizations (including insurers and pre-paid health plans) to permit NAA, Advantage, Partners, DeltaPremier, HRI, or EyeMed or their representatives to see or obtain a copy of all medical, prescribed drugs, HIV and mental health diagnoses, and employment and insurance coverage records which pertain to me or any member of my family.

EMPLOYEE SIGNATURE Date HR - ACCEPTED BY: DATE:

HR ONLY: Effective Date: Term Date: A C R I